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FOR ACTION

SUMMARY OF 1991 RECOMMENDATIONS FOR GENERAL RESOURCES
AND SUPPLEMENTARY FUNDING PROGRAMMES

SUMMARY

The present document, known informally as the "round-up" document, has been prepared to facilitate review by the Programme Committee of recommendations for new general resources programmes and supplementary funding proposals. The addendum to the document provides estimates of future expenditures for all the country programmes as well as regional and interregional projects, with a breakdown by sources of funding.

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INTRODUCTION

1. This "round-up" document summarizes all programme recommendations submitted for approval to the Executive Board at its 1991 session. They include recommendations funded from general resources as well as recommendations to be financed from supplementary funding contributions. The paper includes 30 country programmes and 1 recommendation for services for Palestinian children, for which programme recommendations have already been submitted, as well as 2 regional proposals and 10 interregional proposals with general resources recommendations. Of these recommendations, 13 country programmes and 2 regional proposals with annual planning levels not exceeding \$750,000 are included in four regional documents (E/ICEF/1991/P/L.20, E/ICEF/1991/P/L.21, E/ICEF/1991/P/L.22 and E/ICEF/1991/P/L.23).
2. Owing to programme requirements and a higher general resources income, additional amounts are recommended for five country programmes essentially for the same programme cycle as already approved by the Board in earlier years. These are detailed in one document (E/ICEF/1991/P/L.28) and are indicated by an "(A)" after the country name in table 1 of the present paper.
3. In order to meet documentation deadlines, country programme recommendation documents had to be prepared before aggregate financial data were finalized. The recommendations from general resources shown in the country programme recommendations are provisional figures which are also shown in table 1 under the column "Recommended funding from general resources for the period". Final recommended amounts, taking into account unspent balances from earlier programmes at the end of 1990, are shown in the column "New general resources net of available balances". These amounts will be the additional levels for the countries after the programme recommendations have been approved by the Executive Board.
4. The total amount of programmes from general resources recommended for approval at the current session is \$580 million, of which \$566 million represents new general resources net of available balances. The details are shown by region and country in table 1. Breakdowns of new submissions from general resources by different programme fields are provided in table 2.
5. Supplementary funding proposals for 10 countries, 2 subregional and regional projects and 1 interregional fund in the amount of \$121 million, for which no general resources programmes are recommended for approval at the current session, are presented in documents E/ICEF/1991/P/L.24, E/ICEF/1991/P/L.25, E/ICEF/1991/P/L.26, E/ICEF/1991/P/L.41 and E/ICEF/1991/P/L.42. These supplementary funding proposals are also listed separately by region and country in table 1. An "(S)" after the country name indicates a supplementary funding proposal. The total amount of supplementary funding proposals at the current session is \$795 million.

6. A comprehensive picture of approved general resources and supplementary funding for all the countries with which UNICEF cooperates, as well as of regional and interregional programmes, is provided separately in the addendum to the present document. It shows balances as of the end of 1990 of programmes approved earlier by the Board and new recommended general resources for review and approval by the current session of the Board. To provide a total picture of possible financing for the future, unfunded supplementary funding proposals for the country are also shown. Please note, however, that implementation will depend on funds being raised to finance them.

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Table 1

PROGRAMME SUBMISSIONS TO THE 1991 EXECUTIVE BOARD

(In United States dollars)

	Period	Recommended funding from general resources for the period	New general resources net of available balances <u>a/</u>	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Africa</u>					
Angola	1991-1995	11 000 000	10 503 000	27 500 000	P/L.3
Benin (S) <u>b/</u>	1991-1994			2 175 000	P/L.24
Burkina Faso	1991-1992	5 000 000	5 000 000	8 480 000	P/L.27
Burundi (S)	1991-1993			10 035 000	P/L.24
Cameroon	1991-1995	4 900 000	4 707 000	5 665 000	P/L.6
Côte d'Ivoire (A)	1991	1 203 000	1 431 000		P/L.28
(S)	1991-1992			1 020 000	P/L.24
Equatorial Guinea	1991-1995	2 500 000	2 500 000	4 000 000	P/L.20
Ghana	1991-1995	11 625 000	10 922 000	8 500 000	P/L.7
Guinea	1991-1995	9 250 000	7 866 000	15 250 000	P/L.8
Guinea-Bissau (S)	1991-1993			2 060 000	P/L.24
Liberia	1991-1992	1 500 000	1 500 000		P/L.27
Namibia	1991-1992	1 375 000	1 139 000		P/L.27
Niger (S)	1991-1994			7 535 000	P/L.24
Nigeria	1991-1995	65 000 000	65 000 000	60 000 000	P/L.9
Sao Tome and Principe	1991-1995	2 500 000	2 221 000	1 000 000	P/L.20

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Table 1 (continued)

	Period	Recommended funding from general resources for the period	New general resources net of available balances a/	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Africa (continued)</u>					
Swaziland	1991-1995	2 500 000	2 327 000	4 675 000	P/L.20
Zaire	1991-1992	12 400 000	11 891 000	5 000 000	P/L.27
Zambia	1991-1995	7 360 000	7 274 000	21 485 000	P/L.4
Zimbabwe	1992-1996	6 000 000	5 881 000	6 500 000	P/L.5
Regional:					
Strengthening national capacity- building for child survival and development (S)	1992-1994	_____	_____	5 580 000	P/L.42
Total, Africa		144 113 000	140 162 000	196 460 000	
<u>Americas and the Caribbean</u>					
Argentina	1991-1995	3 750 000	3 750 000	3 000 000	P/L.21
Chile	1991-1995	3 750 000	3 750 000	3 200 000	P/L.10
Colombia (A)	1991-1992	1 168 000	1 168 000		P/L.28
Eastern Caribbean (A)	1991-1992	1 189 000	1 189 000		P/L.28
Ecuador (S)	1991-1993			1 000 000	P/L.25
El Salvador (A)	1991-1992	1 251 000	1 251 000		P/L.28
Guatemala	1991-1992	1 500 000	973 000		P/L.21
Honduras	1991-1995	3 750 000	3 317 000	4 500 000	P/L.11

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Table 1 (continued)

	Period	Recommended funding from general resources for the period	New general resources net of available balances a/	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Americas and the Caribbean (continued)</u>					
Peru (S)	1991-1992			11 000 000	P/L.25
Venezuela	1991-1995	3 750 000	3 750 000	1 500 000	P/L.21
Regional:					
Children in especially difficult circumstances	1991-1996	2 500 000	2 500 000		P/L.21
Subregional:					
Amazon	1991-1994	500 000	500 000	4 500 000	P/L.21
Water supply, sanitation and environmental education: Central America and Panama	1991-1995	_____	_____	<u>20 000 000</u>	P/L.25
Total, Americas and the Caribbean		<u>23 108 000</u>	<u>22 148 000</u>	<u>48 700 000</u>	
<u>Asia</u>					
Bangladesh (S)	1991-1993			48 828 000	P/L.26
Cambodia	1992	3 000 000	3 000 000	9 000 000	P/L.12
China (S)	1991-1994			6 764 000	P/L.26
India	1991-1995	175 000 000	175 000 000	290 000 000	P/L.13
Mongolia	1991-1995	2 500 000	2 430 000		P/L.22

Table 1 (continued)

	Period	Recommended funding from general resources for the period	New general resources net of available balances <u>a/</u>	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Asia (continued)</u>					
Myanmar	1991-1995	25 000 000	23 785 000	15 000 000	P/L.14
Papua New Guinea (A)	1991-1992	1 340 000	1 340 000		P/L.28
Philippines	1991-1993	12 300 000	10 365 000	5 500 000	P/L.15
Sri Lanka (S)	1991-1993			2 000 000	P/L.26
Viet Nam	1991-1995	<u>40 000 000</u>	<u>34 831 000</u>	<u>50 000 000</u>	P/L.16
Total, Asia		<u>259 140 000</u>	<u>250 751 000</u>	<u>427 092 000</u>	
<u>Middle East and North Africa</u>					
Algeria	1991-1995	3 750 000	3 732 000	2 500 000	P/L.17
Oman	1991-1995	3 750 000	3 335 000		P/L.23
Sudan	1991-1995	25 000 000	25 000 000	50 000 000	P/L.18
Palestinian children in the Syrian Arab Republic	1991-1994	800 000	752 000	800 000	P/L.23
Tunisia	1992-1996	3 750 000	3 655 000	2 500 000	P/L.23
Turkey	1991-1995	<u>10 000 000</u>	<u>9 767 000</u>	<u>13 945 000</u>	P/L.19
Total, Middle East and North Africa		<u>47 050 000</u>	<u>46 241 000</u>	<u>69 745 000</u>	

Table 1 (continued)

	Period	Recommended funding from general resources for the period	New general resources net of available balances <u>a/</u>	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Interregional</u>					
UNICEF Maurice Pate Award	1991	25 000	25 000		P/L.1
Bamako Initiative	1992-1994	9 000 000	9 000 000		P/L.30
Participation in the children's vaccine initiative	1991-1993	7 500 000	7 500 000	7 500 000	P/L.31
Children in especially difficult circumstances	1991-1993	900 000	900 000	2 500 000	P/L.32
Control of iodine deficiency disorders	1991-1995	4 955 000	4 955 000	2 750 000	P/L.33
Eradication of <u>dracunculiasis</u> (Guinea worm disease)	1992-1994	4 500 000	4 500 000		P/L.34
Emergency Reserve Fund	1991	5 000 000	5 000 000		P/L.35
Mortality Reduction Reserve	1992-1994	30 000 000	30 000 000	30 000 000	P/L.36
Interregional fund for programme preparation, promotion and evaluation	1992-1993	26 200 000	26 200 000		P/L.37
Regional support for programme preparation, promotion and evaluation	1992-1993	18 475 000	18 475 000		P/L.38
Establishment of a vaccine independence initiative (S)	1991-1995	_____	_____	<u>10 000 000</u>	P/L.41
Total, Interregional		<u>106 555 000</u>	<u>106 555 000</u>	<u>52 750 000</u>	

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Table 1 (continued)

	Recommended funding from general resources for the period	New general resources net of available balances ^{a/}	New supple- mentary funding proposals	Document E/ICEF/1991/
<u>Totals</u>				
Africa	144 113 000	140 162 000	196 460 000	
Americas and the Caribbean	23 108 000	22 148 000	48 700 000	
Asia	259 140 000	250 751 000	427 092 000	
Middle East and North Africa	47 050 000	46 241 000	69 745 000	
Interregional	<u>106 555 000</u>	<u>106 555 000</u>	<u>52 750 000</u>	
Total	<u>579 966 000</u>	<u>565 857 000</u>	<u>794 747 000</u>	
Amounts to cover over- expenditure	345 916	345 916		P/L.39
Grand total	<u>580 311 916</u>	<u>566 202 916</u>	<u>794 747 000</u>	

^{a/} In order to meet documentation deadlines, country programme recommendation papers were prepared before aggregate financial data were finalized. Final recommended amounts, taking into account unspent balances at the end of 1990, are shown in this column.

^{b/} (S) = Supplementary funding proposals only.

(A) = Additional funds for the approved programmes and approved programme cycles as referred to in document E/ICEF/1991/P/L.28.

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Table 2

NEW RECOMMENDATIONS FROM GENERAL RESOURCES BY MAJOR
PROGRAMME FIELD AND REGIONS

(In thousands of United States dollars)

	Africa	Americas and the Caribbean	Asia	Middle East and North Africa	Inter- regional	Total	Per- centage
Health	50 253	1 966	63 470	15 075	46 500	177 264	30
Water supply and sanitation	22 533	290	29 500	6 805	4 500	63 628	11
Nutrition	900	1 215	7 735	490	4 955	15 295	3
Food	8 227		1 605			9 832	2
Education	24 110	917	31 165	7 750		63 942	11
Young child development	70	1 650	54 120			55 840	10
Community organization and development		1 490	11 500	450		13 440	2
Area-based, intergrated and urban services	3 695	800	6 380	6 040		16 915	3
Women-centred programme	2 657	270	21 945	1 775		26 647	5
Children in especially difficult circumstances	1 353	3 460	4 034	1 635	900	11 382	2
Advocacy	7 949	4 922	5 210	1 800		19 881	3
Planning and social statistics	8 227	2 855	4 445	3 860	44 700	64 087	11
Emergency relief and rehabilitation					5 000	5 000	1
Programme support	14 139	3 273	17 815	1 370		36 597	6
Unallocated reserve	—	—	216	—	—	216	0
Total, Programme recommendations	<u>144 113</u>	<u>23 108</u>	<u>259 140</u>	<u>47 050</u>	<u>106 555</u>	<u>579 966</u>	<u>100</u>



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COUNTRY PROGRAMME RECOMMENDATION*

Angola

The Executive Director recommends that the Executive Board approve the country programme of Angola for the period 1991 to 1995 in the amount of \$11,000,000 from general resources, subject to the availability of funds, and \$27,500,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, this document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme co-operation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

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THE SITUATION OF CHILDREN AND WOMEN

1. The impact of the war in Angola has been devastating. Economic infrastructures and key transport routes have been sabotaged; an estimated 25 per cent of primary schools and health units, and 75 per cent of small town and rural water supply systems have been destroyed; government services have been disrupted and personnel intimidated; terrorism and anti-personnel mines have isolated vast tracts of productive rural land; and the war's domination of government resources and spending (40 per cent) has crippled social sector budgets, severely reduced foreign exchange allocations for essential imports (such as drugs) and diverted scarce human resources from the economic and social sectors to essential defence and security. In human terms, the United Nations estimates that since 1980, the war has directly or indirectly contributed to the deaths of some 500,000 young children, caused the handicaps of over 40,000, denied access to basic health and education services for some 2 million, deprived 1.5 million people of safe water supplies, caused the orphaning and/or abandonment of countless thousands of young children and left a legacy that has traumatized and psychologically affected an entire generation.

2. The major problems affecting women and children in Angola today are extremely high rates of infant, young child and maternal mortality; widespread malnutrition and illness; and a chronic lack of food security for the large majority of both urban and rural families.

3. Unlike the downward mortality trends of other sub-Saharan African countries, the trend in Angola is upward. Despite high total fertility rates (estimates range from 6.6 to 8.8 births per woman), population growth (2.6 per cent per annum) has been suppressed by very high mortality rates, which have also contributed to the low life expectancy of 45 years. The under-five mortality rate (U5MR) is estimated at 288 per 1,000 live births and the infant mortality rate (IMR) at 169 per 1,000 live births. In 1988, IMR and U5MR estimates for the capital, Luanda, were 84.4 and 167.2 per 1,000 live births, respectively, while in severely affected areas, these rates were as high as 200 and 375 per 1,000 live births, respectively. Similarly, maternal mortality rates (MMRs) were high, with available data suggesting a range of between 630 and 1,100 per 100,000 live births.

4. The immediate causes of such high mortality rates are neonatal tetanus, diarrhoea, malaria, acute respiratory infections (ARI), malnutrition and measles. High incidences and prevalences of those illnesses are exacerbated by malnutrition. Although data are scarce, malnutrition is widespread among both adults and children. Reflecting poor maternal health, the prevalence of low birth weight is as high as 17 per cent and the prevalence of young child malnutrition ranges up to 40 per cent, while hospital records suggest that up to 50 per cent of under-five hospital mortality is directly attributable to malnutrition.

5. Underlying much of the mortality are a number of immediate causes including massive population displacement and disorientation, low and

declining levels of household food security, low levels of access and utilization of basic (especially health) services and inappropriate young childcare and feeding practices. Those factors are, in turn, sustained by other, more structural causes rooted in the pattern of underdevelopment inherited at independence in 1975, the drought and the results of two decades of war, insecurity and economic stagnation.

6. Reflecting inadequate past investments in education and the destruction and consequent overtaxing of educational infrastructures, the adult literacy rate stands at 28 per cent. Not only is access to primary school extremely limited, but educational efficiency is low, with high repeater and drop-out rates reflecting the poor quality of teachers, the unavailability of teaching materials, high student/teacher ratios and the frequent disruption of the school year due to insecurity.

7. While nationally, access to health services is estimated at 30 per cent, there are significant rural and urban differences. In Luanda, probably the best served city and area of the country, 70 per cent of deliveries occur outside of health facilities and immunization coverage rates are less than 45 per cent. In other cities and secure rural areas, access is significantly less. With limited availability of essential curative and promotive services, combined with poor housing and a congested living environment, both urban and rural populations are subject to constant epidemics (especially cholera and typhoid) which again reflect limited access to potable water supplies (30 per cent) and to adequate sanitation (19 per cent).

8. Food security for most rural households has been undermined by drought, insecurity, low production incentives, limited access to markets and marketing infrastructures and the unavailability of agricultural inputs and extension advice. In urban areas (estimated at 40 per cent of the population), formal sector employment and remunerative informal sector opportunities are scarce, while food prices are extortionate.

9. Available information indicates that over 5 million people suffer from serious food shortages or are severely affected by the war and the drought. Among these are 700,000 people who have been forced to abandon their homes; an estimated 300,000 who have stayed in rural areas, but whose livelihoods are seriously threatened; 1.5 million affected by four consecutive years of drought in the central-southern provinces; and an estimated 2.8 million urban dwellers who, it is estimated, are spending more than 70 per cent of their incomes on food alone. Especially vulnerable within those groups are the female-headed households with high dependency ratios. As able-bodied men have been conscripted by the war, rural and urban women alike have been burdened with increased responsibilities of income generation and providing and caring for the family, while at the same time productive opportunities have declined and social services have either collapsed or function ineffectively.

10. In the medium term, the two most important determinants of child survival and development (CSD) will be peace and the implementation of the economic reform programme. While peace will make more of the vulnerable population

accessible for social service delivery, the economic reform programme will most likely constrain social sector budgets and the capacity to deliver the required services.

PROGRAMME CO-OPERATION, 1987-1990

11. The 1987-1990 programme sought to: (a) increase the coverage, quality and access to essential primary health care (PHC) services; (b) reduce the prevalence of water-borne diseases and the labour burden of water carrying for women by expanding access to potable water supplies; (c) improve the quality of young children's education by training primary and provisional schoolteachers; (d) improve access to early childhood development services through the promotion of appropriate community-based pre-school services; (e) empower women with the knowledge and skills required to protect and promote the survival and healthy development of their children; and (f) provide emergency relief, survival and rehabilitation assistance to vulnerable groups affected by war and drought.

Health and nutrition

12. With considerable investment in the expanded programme on immunization (EPI) and a shift in strategy focus, immunization rates are on the increase. The Luanda universal child immunization (UCI) acceleration strategy has proven effective, with coverage rates increasing from 19 per cent in 1988 to 45 per cent by the end of 1989, and it is expected that the UCI goal will be achieved by the close of 1990. This has led to the expansion of the urban strategy to 5 other major cities in 1990, with plans to cover all 18 provincial cities. In rural areas, the destruction of some 70 health posts has reduced access to immunization. Consequently, efforts have focused on secure rural areas and displaced peoples' settlements, and rural coverage is estimated to be little more than 10 per cent. UNICEF, with support from the Governments of Italy and Sweden, has provided vaccines, cold-chain equipment, transport, training and social mobilization support.

13. Diarrhoeal diseases remain the single most important threat to young children's growth and survival. In Luanda, 70 per cent of mothers are able to practice oral rehydration therapy (ORT) correctly. The Ministry of Health estimates that infant mortality due to diarrhoea has been halved over the past five years.

14. While significant in Luanda, expansion to a national scale has been slow. In other provincial cities, the correct use of oral rehydration salts (ORS) among mothers is lower (50 per cent in Lubango); the 1990 essential drugs evaluation noted with concern the use of inappropriate antibiotics and the 1989 EPI evaluation noted problems with ORS distribution. To address those problems, plans have been modified to accelerate staff training and community education. UNICEF assistance has been utilized to train and equip 140 ORT units; train managers in supervision; provide over 3 million ORS packets; develop and produce mass and community education materials on

diarrhoea prevention and management; and conduct evaluations and operational research activities.

15. To increase access to basic PHC services, UNICEF, with support from the Government of Italy, has provided essential drugs and training support for 40 health posts in Bengo and Kwanza Sul provinces, benefiting 265,000 people. Nationally, over 2,000 traditional birth attendants (TBAs) and 1,500 rural health promoters have been trained and, with support from the United Nations Capital Development Fund (UNCDF), equipment and transport have been provided for the rehabilitation of 40 health centres, 300 health posts and 20 laboratories. Over 2,500 basic drug kits, essential medical equipment for 60 hospitals and health posts, water storage tanks for 30 health centres and light vehicles and bicycles for supervision have been provided.

16. Progress in developing nutrition surveillance, rehabilitation and growth-monitoring services has been slow. Over the past two and one half years, over 300,000 growth charts have been distributed, but in Luanda only 42 per cent of children possess a growth card. In the other main urban areas of the country, card retention rates are lower (27 per cent) and are expected to be lower still in accessible rural areas.

Water and sanitation

17. While limited funding has considerably constrained implementation, water and sanitation activities have been implemented in Malange, Namibe, Huambo, Cunene and Moxico provinces. With assistance from the European Economic Community, UNCDF and the Governments of Australia and the United Kingdom, over 300 boreholes have been rehabilitated and installed with hand-pumps, providing safe water to an estimated 130,000 people. The Huambo hospital water supply system and Luena town pumping station and main pipelines have been rehabilitated. In the Malange project, proximity to safe water was reduced from approximately 600 metres to 100 metres and water consumption increased by 23 per cent in beneficiary households. Progress in strengthening water source maintenance services and in promoting improved sanitation practices has been slower.

Education and care of the young child

18. Over 530 primary and provisional schoolteachers have received in-service training. Through these projects, an estimated 25,000 primary schoolchildren and 1,200 provisional school students have benefited from improved teaching quality, access to teaching and learning materials and the introduction to CSD skills. The community-based pre-school programme has experienced rapid growth. Forty centres in 11 provinces are now operating and provide essential early childhood development services for some 11,270 children aged 2 to 6 years.

Women in development

19. As much as possible, UNICEF concern of UNICEF for women in development has been considered and integrated within sectoral projects. Support was provided to the Organisaçao da Mulher Angolana (OMA) (Organization for Angolan Women), which has supported the training of pump caretakers in Malange, TBAs and health defenders and social promoters who play a leading role in EPI, ORT and family planning education and motivation. The OMA Bureau of Projects and Studies was strengthened with the objective of enhancing the advocacy role of OMA on behalf of women. With the Department of New and Renewable Sources of Energy, investigations have been initiated into appropriate technologies offering economic and labour-saving benefits to women.

Emergency assistance

20. Since 1987, the population recognized as severely affected by drought and war alone has increased considerably - from less than 1 million to over 2.5 million. Despite the limited responses to emergency appeals (only 29 per cent of funding needs have been met), funds have been utilized to: (a) strengthen the advocacy, planning and logistics capabilities of the Unidade Tecnica Administrativa-Emergencia (UTA-E) (Unit for Technical Administration-Emergency), the Secretariado d'Estado dos Assuntos Sociais (SEAS) (Secretariat of State for Social Affairs) and the Ministry of Health to enable them to respond appropriately to developing emergency needs; (b) provide relief and survival assistance; and (c) support resettlement and rehabilitation. Targeting those displaced by war and affected by drought, it is estimated that relief and survival assistance has reached approximately 150,000 people; that supplementary feeding assistance has reached approximately 30 per cent of the displaced population totalling some 210,000 people; and that support to SEAS in strengthening logistics systems has enabled food supplies to be distributed to the vast majority of the displaced population. Resettlement and rehabilitation support have focused on Benguela Province, where approximately 100,000 people have received seeds and agricultural tools to permit the resumption of agricultural activity. In collaboration with the Save the Children Fund, strategies are being developed to trace and reunite families and to provide support to child victims of war.

Social statistics, monitoring and evaluation

21. With UNICEF assistance, the Ministry of Planning undertook a study of the "Social Dimensions of Adjustment in Angola", which was followed by an income, expenditure and nutrition survey of Luanda. The results of this survey will be utilized in policy-making regarding food prices, the introduction of user charges and the consideration of additional safety-net strategies required to minimize the adverse effects of adjustment and protect the urban poor and vulnerable. Efforts have also been directed towards improving statistical databases, as well as the management and dissemination of documentation relevant to planning and monitoring the situation of children in Angola; and strengthening the systems and procedures for joint government/UNICEF monitoring and evaluation of UNICEF-assisted programmes.

Lessons learned

22. The lessons learned during the period 1987-1990 recognize the need to concentrate attention on advocacy, policy formulation and capacity-building with the following main lines of intervention:

(a) Strengthening the focus on the most vulnerable groups to avoid dispersion of scarce resources, increase the impact of essential activities and guide national and international advocacy and fund-raising efforts;

(b) Increasing the emphasis on policy and strategy formulation, linking emergency (short-term) rehabilitation and reconstruction with development (medium- to long-term) programme concerns;

(c) Giving priority to local-level programming in pursuit of national objectives. This strategic orientation recognizes the need to make efficient use of scarce UNICEF resources so as to achieve a lasting and sustainable impact through more integration and complementary action at the provincial level and improved targeting in a number of selected provinces, bearing in mind levels of vulnerability, success factors and potential for replicability. Lessons learned through this process of planning and programme interventions at subnational levels will, in turn, influence government thinking and the search for more adequate planning and decision-making methods. Area-based programming may not be feasible in the short or medium term, but the approach advocated enables the Government to test ideas regarding the decentralization of decision-making and resource allocation, which are essential elements for effective area-based programming;

(d) Giving increased support to national institutional capacity-building in policy formulation, planning, management, monitoring and evaluation; and improving information collection, analysis and use.

RECOMMENDED PROGRAMME CO-OPERATION, 1991-1995

Recommended general resources: \$11,000,000

Supplementary funds: \$27,500,000

Recommended programme co-operation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Primary health care and nutrition	2 360	13 280	15 640
Water, sanitation and hygiene	1 305	11 530	12 835
Education and children in especially difficult circumstances	2 250	-	2 250
Social mobilization, communications and advocacy	660	730	1 390
Planning for women and children	1 135	360	1 495
Country programme support	2 600	-	2 600
Area-based programmes:			
Luanda child survival and development	380	310	690
Huila basic services	<u>310</u>	<u>1 290</u>	<u>1 600</u>
Subtotal, Area-based programmes	<u>690</u>	<u>1 600</u>	<u>2 290</u>
Total	<u>11 000</u>	<u>27 500</u>	<u>38 500</u>

a/ The breakdown for estimated yearly expenditures is given in table 3 below.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programme preparation

23. The Government and UNICEF have agreed upon common strategies best suited to promote CSD in Angola's current circumstances. The mid-term review in 1989 was followed by a series of strategy meetings to define future programme strategies, goals and objectives and major programme components.

Programme goals and strategies

24. The overall goal is to improve the situation of Angolan children and women by developing a series of mutually supportive services. Recognizing that high mortality and malnutrition rates reflect, and are sensitive to, the deeper problems Angola faces, over the programme period, the country programme seeks to reduce IMR from an estimated 170 to 145 per 1,000 live births; reduce U5MR from an estimated 290 to 255 per 1,000 live births; reduce MMR to below 400 per 100,000 live births; and reduce the prevalence of acute malnutrition among children under five years of age by 50 per cent.

25. In responding both to the immediate needs of vulnerable groups and to the underlying and more structural causes of their vulnerability, the programme combines complementary strategies providing short-term relief and survival assistance for populations affected by war and drought, as well as medium- to longer-term support for the rehabilitation of basic services, the promotion of household food security and the development of national capacities.

26. Targeting the urban poor, the rural displaced and those affected by war and drought, the programme will integrate those strategies and will be articulated primarily through a geographic convergence of UNICEF regular and emergency programme assistance within the six more populous and worst affected provinces: Luanda, Bengo, Kwanza Sul, Benguela, Huila and Cunene. Additional support will be provided to two of the provinces, Luanda and Huila, to strengthen subnational planning and the appropriate community participatory approaches.

27. Programmes supported nationally will promise a cost-effective impact on child mortality and women's well-being. Paramount among those will be accelerated immunization and CDD activities; communication and social mobilization to increase mothers' child-care abilities and promote health service utilization; and the strengthening of statistical and information systems to improve characterization and monitoring of vulnerable groups, allow for better decision-making and improve targeting of advocacy efforts.

Emergency

28. The emergency programme will combine short-term measures to avert death and suffering with medium- to longer-term measures enabling the rehabilitation of basic social services, family resettlement and the re-establishment of household food security.

29. Emergency programme activities will be expanded under the Special Relief Programme for Angola (SRPA), with particular attention to the nine provinces worst affected by drought and war (Kwanza Sul, Benguela, Huambo, Bie, Moxico, Kuando Kubango, Huila, Namibe and Cunene). Within those provinces, the efforts of UNICEF, the World Food Programme, non-governmental organizations and local programmes will aim to ensure the effective targeting and monitoring of food; assist displaced and drought-affected families to re-establish agricultural and pastoral production through the provision of essential inputs (seeds, tools and cattle vaccines); and improve access to immunization, basic health services and safe water supplies.

30. With SEAS, family tracing systems will be expanded to reintegrate orphaned or abandoned children, while community approaches will be developed to support children psychologically and physically affected by war. Training and planning assistance will also be provided to national authorities, particularly UTA-E, SEAS and Provincial Emergency Commissions.

Planning for women and children

31. In promoting government capacity to minimize the negative impacts of economic adjustment on poor and vulnerable groups, the Ministry of Planning will be assisted in establishing systems to monitor the "micro adjustments" made by households in response to policy changes, as well as their impact on the nutritional status and well-being of children and women. Studies will be supported to analyse the potential impacts of possible policy measures and their implications.

32. The National Institute of Statistics will receive support to establish a national database on the situation of women and children; strengthen its information collection, management and analytical capabilities; establish regular mechanisms for the dissemination of statistical data; and strengthen joint government/UNICEF monitoring of the country programme and key goals and objectives of the Fourth United Nations Development Decade (1991-2000). UNICEF will assist the Government in reviewing the situation of children in Angola and in preparing, in 1991, a National Programme of Action for the achievement by the year 2000 of the goals endorsed by the 1990 World Summit for Children.

Primary health care and nutrition

33. At the national level, EPI seeks to increase the proportion of fully vaccinated infants and pregnant women to 75 per cent. Specific targets are to reduce measles morbidity nationally by 50 per cent and neonatal mortality due to tetanus by 75 per cent in the seven largest cities. To achieve those targets, the urban UCI acceleration will be expanded to all provincial capitals, fixed-post and mobile maternal and child health/EPI services will be extended to secure rural areas and settlements of the war-displaced and vaccination services extended into insecure areas made accessible by the SRPA.

34. To reduce morbidity and mortality attributable to diarrhoeal diseases by 20 per cent and 25 per cent, respectively, extensive health education, social mobilization and health worker training will be conducted to ensure that 60 per cent of mothers are capable of providing correct case management of diarrhoea, that 80 per cent of the population has access to ORS and that 50 per cent of mothers know and practice at least three measures to prevent childhood diarrhoea. A total of 18 provincial-level diarrhoea training units will be established, all health staff and units will be equipped to provide correct case management and over 4,000 health and social promoters will be trained in diarrhoea management and prevention.

35. UNICEF will also assist the Ministry of Health to develop appropriate strategies for ARI prevention and management, with the objective of reducing mortality due to ARI by 20 per cent. The programme aims to improve the skills of health workers in the management of children with coughs and progressively to expand the role of community health promoters.

36. Complementing assistance from the Government of Sweden to the national essential drugs programme, UNICEF will provide essential drugs and training support for 180 health units in the provinces of Bengo and Kwanza Sul. Benefiting a population of over 1 million, priority attention will be focused on improving health workers' skills in managing common illnesses of women and children, in addition to educating mothers about the timely referral of sick children and the importance of following treatment schedules.

37. Responding to the high MMR, safe motherhood services will be strengthened with the objectives of increasing antenatal attendance to 70 per cent of pregnant women and increasing the proportion of institutional deliveries from 16 to 25 per cent. Complementing the support of the United Nations Population Fund, the Government of Sweden and the International Planned Parenthood Federation in promoting family spacing and improved obstetric services, UNICEF assistance will be directed towards the training of 2,400 TBAs and 130 TBA trainers. Through these efforts, the project seeks to ensure that all women having antenatal contact are immunized against tetanus, receive iron supplements and malaria prophylaxis and are educated about acquired immunodeficiency syndrome (AIDS), child spacing and maternal nutrition and care. At the community level, UNICEF assistance will be provided for the training of 1,800 community rural health promoters who, working in collaboration with TBAs, will provide limited curative services and community health education.

38. To provide mothers with timely and appropriate child-care advice, growth monitoring and promotion activities will be reinforced and expanded at the health centre and community levels. Overall, the project seeks to increase to 75 per cent the proportion of infants attending at least four growth monitoring sessions; increase to 25 per cent the proportion of children aged 12-35 months attending at least two such sessions; and increase to 30 per cent the proportion of mothers understanding the growth chart and exclusively breast-feeding their children until at least four months of age.

39. To improve Ministry of Health capabilities in monitoring and evaluating the coverage and impact of its PHC programme, assistance will also be provided to strengthen health information systems and expand the system of sentinel sites. Continued support will be provided to improve logistics systems and to reinforce, through training, the emergency planning and management skills of PHC managers.

40. Contributing to the overall country programme objective of reducing by 50 per cent the prevalence of acute malnutrition among children under five years of age, nutrition strategies will focus on improving understanding of the nutritional problems of children and women; advocating greater consideration of the effects on nutrition of policy decisions on emergency programmes, development and structural adjustment; and strengthening national capacities to target, manage and assess the impact of rehabilitation and food distribution programmes on vulnerable groups.

Water, sanitation and hygiene

41. Overall programme objectives are to reduce ill health among children and women due to poor water supplies, sanitation and hygiene (specifically to reduce by 20 per cent the incidence of diarrhoea morbidity in children under five years old); and to reduce the labour burden of women carrying water. Within the provinces of Huila, Cunene and Bengo, over 620 boreholes, 300 hand-dug wells and six small-scale rural and peri-urban water-supply systems will be rehabilitated or constructed, providing access to safe water for approximately 350,000 people. Maintenance services will be strengthened through the training and equipping of over 1,000 community pump or standpipe caretakers, the establishment of 13 municipal water source and hand-pump maintenance brigades and the equipping and training of three provincial-level maintenance teams. The programme seeks to increase the proportion of fully functioning hand-pumps and water points from present baseline estimates of 25-40 per cent to 75-80 per cent by 1995.

42. Some 3,500 pit latrines will be constructed within rural settlements for the war-displaced in peri-urban areas and at primary schools and clinics. The sanitation promotion component will be accompanied by an intensive hygiene communications strategy targeted primarily at women, young girls and primary schoolchildren. Support will also be provided to the National Directorate for Water to prepare a water and sanitation sector policy and action plan for the 1990s and to strengthen the Directorate's capacity to co-ordinate, monitor and support technically its implementation. To strengthen government capacity in borehole construction and rehabilitation, technical assistance will be provided to train and supervise drilling crews working in Huila and Cunene provinces; to improve the effectiveness of its hydrogeological and geophysical testing services; to train staff in water quantity and quality testing; and to strengthen capacity to ensure the full serviceability of the vehicles and equipment employed in the programme.

Education and children in especially difficult circumstances

43. The Government has designated 1991-1995 for a major review and reformulation of educational strategies and options. The education programme will strengthen national capacities for assessment of needs; identify options and strategies; advocate greater family and community awareness, support and initiatives; and provide more effectively delivered and relevant methodologies, materials and services in pre- and primary school education.

44. In pre-school education, projects will strengthen teacher training; target more services to children of poor female-headed households in peri-urban and rural areas; and stimulate community alternatives for accomplishing this goal. In primary education, staff training will be strengthened, particularly with respect to teaching skills in critical subject areas, and recognition of and attention to the needs of children in especially difficult circumstances who enter the regular school system.

45. While the programme stresses support to the Ministry of Education, the future National Institute of the Child and the Ministry of Health are also intrinsic to programme implementation. Underlying all interventions will be strategies to increase awareness of children's rights in Angola, which has recently signed the Convention on the Rights of the Child.

Social mobilization, communications and advocacy

46. While messages promoting improved maternal and child-care practices will be developed on the basis of research conducted by the various sector programmes, additional support will be provided to the Ministry of Information to research, develop, target and evaluate the impact of CSD and Facts for Life messages communicated through radio. To complement mass communications approaches, networks of CSD promoters and communicators - comprising members of the various political and mass organizations and NGOs - will be formed in six provinces and their members will be trained in effective CSD communications and mobilization techniques.

Area-based programmes

47. In Luanda, the entry point for developing more comprehensive basic services and poverty alleviation strategies will be to promote the survival, health and well-being of vulnerable and poor urban households during the period of economic adjustment. City-wide approaches will be based on the experience gained within the two poorest areas of Cazenga and Kilamba Kiaxi, where community-based sentinel sites have been established to provide continuous community assessments, mobilize community action and monitor the impact of actions and interventions.

48. In Huila province, regular and emergency assistance will be programmed to strengthen the capacities of provincial authorities in planning and managing the rehabilitation of basic services. Priority attention will be directed to increasing access to safe water supplies from 10 to 40 per cent, establishing

water maintenance services and promoting improved sanitation and hygiene practices among a target population of 170,000.

49. In the district of Chibia, collaboration with the Agricultural Development Institute will continue with the purpose of improving rural extension methods for working with peasants' associations.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Angola (1989 and earlier years)			UNICEF country classification			
Under-five mortality rate	292 _a /	(1989)	Very high U5MR			
Infant mortality rate	173 _a /	(1989)	Very high IMR			
GNP per capita	\$ 1130	(1987)	Lower-middle GNP			
Total population	10 million	(1989)				
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT			1970	1980	1985	1989
Births	(thousands)		277	354	405	449
Infant deaths (under 1)	(thousands)		50	55	67	78
Under-five deaths	(thousands)		84	92	114	131
Under-five mortality rate (per 1,000 live births)			302 _a /	261 _a /	281 _a /	292 _a /
Infant mortality rate (under 1) (per 1,000 live births)			180 _a /	155 _a /	166 _a /	173 _a /
			About 1980	Most recent		
Underweight children (under 5)	Moderate & severe		..	..		
(% weight for age, 1980/1987)	Severe		..	..		
Babies with low birth weight (%, 1979/1988)			19	17 _b /		
Children completing primary level (% of first grade, 1980/1988)			24	..		
NUTRITION INDICATORS			About 1980	Most recent		
Mothers breast-feeding at 3/6/12 months (%, 1980/1985)			.. / 96 _c /..	.. / 91 _c /..		
Prevalence of wasting (%, 1980/1985)			..	..		
Prevalence of stunting (%, 1980/1985)			..	..		
Daily per capita calorie supply (% of requirements, 1979-1981/1984-1986)			92	82		
Food production per capita index (Index 1979-1981=100, 1980/1989)			101	80		
Household expenditure (% of total income, 1980-1985)	All food/cereals			.. / ..		
HEALTH INDICATORS			About 1980	Most recent		
ORT use rate (%, 1987-1988)				12		
Access to health services	Total		30	..		
(% of population, 1980/1987)	Urban/rural		.. / ..	.. / ..		
Access to safe water	Total		21	30		
(% of population, 1980/1987)	Urban/rural		85 / 10	87 / 15		
Access to adequate sanitation	Total		22	19		
(% of population, 1980/1987)	Urban/rural		40 / 15	29 / 16		
Births attended by trained personnel (%, 1980/1984)			..	15		
Maternal mortality rate (per 100,000 live births, 1979/1987)			..	..		
Immunization			1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis		..	30 _d /	32	46
	DPT		..	19 _d /	12	18
	Polio		..	13 _d /	13	19
	Measles		..	44 _d /	56	42
Pregnant women (%) immunized against	Tetanus		..	54 _d /	19	23

TABLE 1 (continued)

Angola

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1984)	Total	158/	..	93/	..	
	Male	.. /	..	.. /	..	
	Female	.. /	..	.. /	..	
Secondary enrolment ratio (gross/net) (%, 1980/1984)	Total	19/	..	13/	..	
	Male	.. /	..	.. /	..	
	Female	.. /	..	.. /	..	
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	12		36		
	Male/female	16/	7	50/	23	
Radio/television sets (per 1,000 population, 1980/1988)		26/	4	50/	6	
DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	5.6	7.7	8.8	9.7	13.3
Population aged 0-15 years	(millions)	..	3.6	4.1	4.6	6.3
Population aged 0-4 years	(millions)	..	1.4	1.6	1.8	2.4
Urban population (% of total)		15	21	25	28	36
Life expectancy at birth (years)	Total	37	41	43	45	50
	Male	36	39	42	44	48
	Female	39	43	45	47	51
Total fertility rate		6.4	6.4	6.4	6.4	6.0
Crude birth rate (per 1,000 population)		49	47	47	47	45
Crude death rate (per 1,000 population)		27	23	21	20	16
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1976/1987)		1		..		
Population annual growth rate (%, 1965-1980/1980-1989)	Total	2.8		2.6		
	Urban	6.4		5.7		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		..		..		
Inflation rate (%, 1965-1980/1980-1988)		..		..		
Population in absolute poverty (%, 1977/1988)	Urban/rural	.. / ..		.. / ..		
Household income share (%, 1977/1988)	Top 20%/bottom 40%	.. / ..		.. / ..		
Government expenditure (% of total expenditure, 1980/1987)	Health/education	.. / ..		6* / 15*		
	Defence	..		34*		
Household expenditure (% of total income, 1980-1985)	Health/education	.. / ..		.. / ..		
Official development assistance: (1980/1988)	\$US millions	53		157		
Debt service (% of goods & services exports, 1980/1988)	As % of GNP	2		..		
		..		..		

a/ Provisional estimates.b/ Luanda only.c/ Duration not stated.d/ Half the country only.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: ANGOLA
LATEST BOARD APPROVAL: 1987
GENERAL RESOURCES: \$5,924,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	608	3312	3	7	761	655		501	1372	4475	5847
Water supply and sanitation	142	2221			856	1064	75	46	1073	3331	4404
Nutrition	26	280			27	191	21	76	74	547	621
Education	437				246		215	9	898	9	907
Community organization and development	5	40					4		9	40	49
Women-centred programme	60	25	13		137	69	36	54	246	148	394
Advocacy						67		65		132	132
Emergency		10601		2		956		317		11876	11876
Planning and project support	255		21		622	84	710	47	1608	131	1739
Freight	161	1150							161	1150	1311
GRAND TOTAL	1694	17629	37	9	2649	3086	1061	1115	5441	21839	27280

GR = General resources.

FSF = Funded supplementary funding.

/...

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: ANGOLA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	450	470	470	480	490	2360
	NSF	2700	2700	2650	2600	2630	13280
Water supply and sanitation	GR	275	290	240	245	255	1305
	NSF	2460	2300	2270	2300	2200	11530
Education	GR	450	450	450	450	450	2250
Social mobilization and advocacy	GR	115	120	160	125	140	660
	NSF	170	150	140	140	130	730
Planning and social statistics	GR	270	240	210	240	175	1135
	NSF	60	70	70	80	80	360
Programme support	GR	480	500	540	530	550	2600
Integrated area-based programme (Luanda CSD programme)	GR	80	80	70	70	80	380
	NSF	40	60	70	60	80	310
Integrated area-based programme (Huila basic services programme)	GR	80	50	60	60	60	310
	NSF	70	220	300	320	380	1290
TOTAL	GR	2200	2200	2200	2200	2200	11000
	NSF	5500	5500	5500	5500	5500	27500
GRAND TOTAL		7700	7700	7700	7700	7700	38500

GR = General resources.

NSF = New supplementary funding.

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: ANGOLA	Number of posts	Amount (thousands of United States dollars)

FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	4	1091
Local national Professional and General Service established posts	11	692
Operating costs		1061

Total	15	2844

FINANCED FROM PROGRAMME FUNDS: ^{a/}		
International Professional project posts		
General resources	8	1670
Supplementary funds	15	3041
Local national Professional and General Service project posts		
General resources	20	1036
Supplementary funds	17	880

Total	60	6627

^{a/} For information source, see 1992 post authorization table, dated January 1991.



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1991 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Zambia

The Executive Director recommends that the Executive Board approve the country programme of Zambia for the period 1991-1995 in the amount of \$7,360,000 from general resources, subject to the availability of funds, and \$21,485,000 in supplementary funds, subject to the availability of specific-purpose contributions.

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

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THE SITUATION OF CHILDREN AND WOMEN

1. The programme has been prepared during a momentous period of political change and economic reforms. In September 1990, after a vigorous national debate, it was announced that Zambia would change to a multi-party system. A commission is working on the required changes in the constitution and elections are scheduled for 1991.
2. The recent energy crisis, which resulted in a 400 per cent increase in domestic fuel prices, has further exacerbated long-standing economic problems. Per capita income is now estimated to be less than \$300. In 1989, Zambia initiated an economic reform programme of fiscal and monetary restraint and revenue enhancement measures, together with a restructuring of economic incentives to stimulate production. The economy remains extremely vulnerable to external shocks. Agricultural production is largely dependent on rainfall, and a major drought would seriously threaten food security and could even halt the tentative economic recovery process. The external debt exceeds \$7 billion, almost four times the gross national product (GNP), and, therefore, high international interest rates have serious consequences for the country.
3. The impact of adjustment and external economic shocks on children and women, especially the urban poor, is severe. The decontrol of prices, the elimination of subsidies and the energy crisis have dramatically increased the prices of essential items such as transport, food, rents and utilities. The annual inflation rate in 1990 was estimated to be 120 per cent. Basic services are increasingly under pressure since budget allocations do not keep pace with inflation, and both the quality and coverage of services have been adversely affected by low pay and the exodus of trained staff. To mitigate the potentially serious impact of adjustment on the poor and vulnerable and to facilitate the participation of the poor in the economic recovery, the Government established a social action programme as an integral part of the public investment programme for 1990-1994 which covers health and nutrition; education; water and sanitation; urban and rural roads; market places and transport; women in development; income and employment through accelerated public works projects; and the development of small-scale enterprises.
4. In spite of economic difficulties and past geopolitical problems, Zambia has made substantial progress in improving social services and the welfare of children and women. The under-five mortality rate dropped from 228 per 1,000 live births in 1960 to 125 in 1989, access to health care improved owing to a network of over 1,000 health facilities and universal child immunization (UCI) was reached in 1988. This progress is now threatened by the economic crisis and by the spread of acquired immunodeficiency syndrome (AIDS), which may even reverse these achievements. According to UNICEF field office estimates, AIDS could increase the child death rate by 20 per cent or more in the coming years. Other major causes of infant and child mortality include disorders of the new-born and perinatal period, respiratory infections, diarrhoeal diseases, malnutrition, malaria and measles.

5. The principal causes of maternal mortality, which is estimated to be 200 per 100,000 live births, are related to infection and poor pre-natal care, rather than to the physical complications of pregnancy. The World Health Organization (WHO) estimates that the death rate among women of child-bearing age will increase 200 to 300 per cent in countries where human immunodeficiency virus (HIV) infection is high.

6. Both moderate and severe malnutrition rates, which are traditionally high at 25 to 30 per cent, are also thought to be increasing as a result of several factors, including deteriorating economic conditions, inflation, the reduction of food subsidies and the rapid spread of HIV infection.

7. Primary school enrolment remains high (over 90 per cent), but enrolment steadily declines up to the seventh grade (the end of primary school), so that less than 80 per cent of children complete primary school. In rural areas, the progression rates from grade 4 to grade 5 are significantly low. The illiteracy rate has declined from about 70 per cent at independence in 1964 to around 25 per cent, but there are still more than 1 million illiterates, of whom some two thirds are women.

8. Zambia is already more than 50 per cent urbanized. Annual urban population growth is 6 per cent, four times faster than the rural population, which places a great strain on urban services. The densely populated squatter areas lack access to water, sewage and drainage. The estimates of access to clean water (40 per cent of the rural population and 76 per cent of the urban population) are probably too high.

9. Growing numbers of children are being orphaned by AIDS, and estimates suggest that tens of thousands of children may be affected over the next five years. Many of those children will be in urban areas and this is likely to create a major problem of street children.

PROGRAMME COOPERATION, 1987-1990

10. The country programme for 1987-1991 has been reduced to four years because the annual programme budget levels were increased and the approved funds were disbursed ahead of schedule. Implementation of some components has been slow, and some redesigning was necessary in order to reformulate certain objectives and strengthen implementation capacity.

11. The maternal and child health (MCH)/UCI project represented roughly 75 per cent of the total UNICEF financial input. Initial progress was very encouraging. A national survey in 1988 showed that UCI had already been achieved and sentinel sites reported a decline in disease incidence. However, a combination of recurrent budget limitations, logistic and organizational problems, competing health priorities and slackening social mobilization led to a decline in vaccination coverage in 1989. This trend was reversed in 1990 as a result of intensified social mobilization, focusing on national immunization days, and increased technical and financial support. Cooperation

with the Church Medical Association of Zambia, which is responsible for up to 40 per cent of rural health care, was very positive in the control of diarrhoeal diseases (CDD) and MCH/UCI, including the training of traditional birth attendants (TBAs) and child health workers, and more recently in health financing and district management.

12. The CDD project emphasized training. Some 70 district trainers were equipped to undertake UCI/CDD training in their districts where they, in turn, organized training for 1,100 health workers in case management, use of oral rehydration therapy (ORT) and communication. The Diarrhoea Training Unit opened in 1990. Problems experienced in the local production and distribution of oral rehydration salts (ORS) are being addressed by an inter-agency working group. The use of ORS increased from 1 million sachets in 1986 to 3.5 million in 1990, and a local production capacity has been created that can meet approximately 35 per cent of this consumption.

13. The sexually transmitted diseases (STDs) project supported a national network of more than 40 STD clinics, with joint training programmes and the provision of laboratory kits. Intensive counselling and health education efforts in antenatal clinics have increased service quality, and 30 clinical officers have been trained.

14. The national nutrition surveillance programme, which has provided regular growth monitoring, aims to increase the effectiveness of nutrition activities within primary health care (PHC) and to influence policy makers and planners to take nutrition-related factors into account in designing development policies and programmes. However, activities have been constrained by under-staffing, the lack of office space and computers, logistics problems and inadequate recurrent budgets. Following a technical review supported by the Government of Sweden, the programme is being reoriented, with priority being given to improving the quality and effectiveness of growth monitoring and its extension to the community, and to intensifying practical measures for the prevention and treatment of child malnutrition.

15. In the health sector, the major implementation problems were weak coordination and management capacities, lack of technical expertise in specific areas, staff shortages, inadequate monitoring and health information systems, lack of recurrent budgets and deficient accounting and disbursement procedures.

16. The household food production and income-generation project assisted 600 women in three districts. The women are organized in groups of 20, according to the national lima (a farming system) group development strategy. Although agricultural production increased, the project had limited lasting impact on women's welfare and has experienced managerial and implementation problems. The project structure is not sustainable; the revolving fund has not operated effectively and the system for input distribution tended to encourage dependency of the beneficiaries on the donor agency supply line. Furthermore, in the field, the project has been perceived as a UNICEF project and has not been integrated fully into the mainstream activities of the

Ministry of Agriculture. Modifications are being made to ensure that by 1992 these women's groups can link up with the cooperative movement or other local structures that can provide advice and inputs.

17. The integrated rural women's education and child survival and development (CSD) project has assisted 400 women, usually heads of household, in two districts of Luapula Province. Managed by a national coordinator in the Provincial Planning Unit, the project has faced coordination problems between planners and line ministries, delays in the delivery of inputs, slow disbursement and weak institutional support. Nevertheless, agricultural production and access to health care have improved in the participating communities and a basis has been established for project expansion. The problems encountered have been addressed by a review team whose recommendations for a comprehensive redesign have been incorporated into the new programme.

18. The child-to-child project used children to communicate health messages to other children, as well as to the family and community. Initial management problems have been overcome through training and the reallocation of responsibilities. The project has developed close ties with the Curriculum Development Centre and the Ministry of Health and has worked mainly through six teacher-training colleges and 25 associated schools. Targeted training of teachers was conducted and links are being developed with the family and community. In Mpika and other districts, sketches and songs by child-to-child groups at schools have informed mothers about immunization and other health activities.

19. The functional literacy project supported literacy and training for women and girls through the network of social development centres and women's clubs. Activities included the development of materials and the strengthening of supervision, sensitization seminars and baseline data collection. A major review of literacy activities and learning opportunities for women and girls has been completed, of which the results form the basis of a new national strategy to reduce illiteracy.

20. The planning, monitoring and evaluation project has strengthened planning, data collection and analysis in areas such as food and nutrition policy as related to the adjustment programme. A survey of malnutrition was conducted in conjunction with the periodic crop forecasting survey and a bulletin of socio-economic indicators and analysis is being published.

Lessons learned

21. In programme design, there is a need for more attention to project management issues, including coordination, communication, supply and logistics, as well as to ensuring a better match between project objectives and available human and financial resources. Recurrent budget allocations need to be increased, either from domestic or external sources, and disbursement and accounting procedures should be streamlined.

22. Social mobilization has demonstrated its potential for mobilizing support for UCI. Here the personal involvement and commitment of the top leadership has been decisive and must be maintained. The progress in immunization also demonstrates the value of a clear focus and well-understood objectives, supported by careful planning and monitoring and the strengthening of delivery systems. The use of targets is a powerful mobilization and managerial tool, but requires the strengthening of monitoring and routine information systems so that progress can be measured. The experience of the present programme indicates that staffing, both in quality and quantity, is a decisive factor. Training needs to be more professionally organized, with increased involvement of training institutions and more attention to management skills such as budgeting and supervision, as well as technical areas.

23. There must also be supportive personnel and training policies reinforced by a strengthened supervisory system. To conserve scarce management time, resources should be concentrated on flexible sectoral programmes, rather than fragmented among separate projects. For more efficient management, implementation responsibilities, along with the required resources, should be decentralized wherever possible to the locus of action, usually the district or community level.

24. The present programme underestimated the severity and duration of the economic crisis. The new programme is based on a more realistic appraisal of available national and local resources. It includes targeted support for recurrent budgets and improved cost monitoring and analysis in the framework of strategies to mobilize domestic resources in the medium term, including the reallocation and expansion of central budgets and increased district and community financing. A costing study of immunization and a report on existing community financing initiatives and their potential for expansion have been prepared.

25. Another major lesson of the present programme is that activities to increase the income and improve the conditions of women must be better adapted to the prevailing economic environment, and require technical guidance in areas such as credit, marketing and technology. In these projects, and also in relatively new programme areas such as AIDS and informal education, closer collaboration should be sought with church groups and non-governmental organizations (NGOs), who are accomplishing pioneering work.

RECOMMENDED PROGRAMME OF COOPERATION, 1991-1995

Recommended general resources: \$ 7,360,000
Supplementary funds: \$21,485,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Primary health care	3 310	11 700	15 010
Basic education	1 840	7 500	9 340
Planning and social statistics	735	-	735
Community-based child survival and development	<u>1 475</u>	<u>2 285</u>	<u>3 760</u>
Total	<u>7 360</u>	<u>21 485</u>	<u>28 845</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

Programming process

26. The proposed programme is based on a review of the present programme and on the situation analysis of children and women, and the goals and priorities are consistent with the Fourth National Development Plan (1989-1994) and the social action programme. Major bilateral donors have also been involved. The programme builds upon the experience gained during the present cycle, and seeks to strengthen the positive features and overcome the implementation problems encountered.

Programme strategy

27. The programme contributes to the national effort to reduce under-five and maternal mortality and morbidity, although the achievement of specific reduction targets may not to be feasible in view of the spread of AIDS and the extent of poverty. The programme strategy responds to the main causes of child and maternal deaths: poor quality and coverage of services, especially health (PHC); poor socio-cultural conditions, especially lack of education, information and low status of women (Education for All); and household poverty, food insecurity and malnutrition (community-based child CSD).

/...

28. The country programme consists of national programmes in health, education and social planning, in addition to an area-based programme composed of district-specific rural and urban community-based projects. The emphasis is on strengthening programme planning and management, including the budget process and monitoring and evaluation, and on the more efficient and effective use of existing resources and infrastructure. It reflects the "adjustment with a human face" strategy of protecting essential services, food security and incomes of the poorest and of monitoring social indicators. Intensive efforts will be made to ensure maximum complementarity and synergism between major programme components. Successful community-based approaches developed in the area-based programme will be integrated into the national programmes, while the planning and social statistics project will use field information gained from the other programmes.

29. The major part of UNICEF investment goes to interventions with a direct impact on poor children and women, but in recognition of the need to refine policy goals and targets and to strengthen systems, the programme also supports policy development and analysis (including innovative pilot activities) and capacity-building (including government and non-government institutions, rural and urban district administration and community organizations).

30. Social mobilization is an integral part of the programme. The aim is to strengthen national commitment to, and popular support and demand for, CSD and to improve implementation through the development of communication networks. Social mobilization is especially important in the prevention of AIDS and the promotion of education for all. Priority will be placed on harnessing the potential of "third channel" learning opportunities such as churches, women's groups and the media. The notions of a "learning society", the "empowerment" of communities and the building of confidence through knowledge are central to the programme strategy. Another theme that will strongly influence programme targetting is disparity reduction in general, with a special emphasis on the gender gap.

Programme objectives and goals

31. The overall goals are: (a) to reduce child mortality and improve child health; (b) to reduce maternal mortality and to improve women's health; (c) to develop effective methods to reduce poverty and malnutrition, with the participation of the poor; (d) to strengthen decentralized district management of services and to develop a framework for community-based management; and (e) to reduce illiteracy and to expand access to basic education and learning opportunities for primary school-age children, adolescents and women.

32. The programme does not specify quantitative nutritional objectives because of the fluidity of the situation. However, it has the general objective of preventing an increase in malnutrition and gradually reducing its high prevalence. Furthermore, if the specific goals of each project are achieved, the economy improves and adequate social policy is implemented by the year 2000, Zambia may achieve the following global nutritional goals:

(a) the reduction of both moderate and severe undernutrition to one half of 1990 levels; (b) the virtual elimination of vitamin A and iodine deficiency; and (c) the reduction by 30 per cent of iron deficiency anaemia in women.

Health

33. The PHC programme incorporates the Bamako Initiative strategy and aims to reduce mortality and morbidity of children and women through nation-wide interventions, with integration at district and health centre levels, and the development of systems for community management and financing. At the service provision level, support will strengthen PHC delivery, especially specific services such as immunization. At the institutional level, the focus is to increase the capacity of human and organizational systems to support PHC, including national institutions. At the policy level, the programme will support the development of government policies to respond best to health needs and to mobilize resources for health.

34. The objective of the maternal health/safe motherhood programme is to reduce maternal and perinatal mortality and morbidity by improving the coverage and quality of care, with an emphasis on high-risk individuals and groups. The status of women will be enhanced by providing information on health services and practices to protect their health. Staff training and the provision of equipment and diagnostic facilities will improve the quality of antenatal and post-natal care as part of an integrated PHC package, identifying high-risk women. This is part of the national MCH programme that is supported by the United Nations Population Fund (UNFPA) and WHO. TBAs will be trained to provide safe home deliveries and to play an important educational and mobilizing role. The prevention of maternal deaths will be assured through the referral of high-risk cases for obstetric care at appropriate levels of the existing health delivery system, although direct support in this area will be provided by other donors. UNFPA will support the family health programme, which places emphasis on birth spacing through MCH services and NGO channels. Coordination will be important in community education and mobilization, as a contribution to the empowerment of women. The importance of women's health, adequate care for all pregnancies and referral of high-risk cases for institutional delivery will be emphasized in all education and mobilization activities. Young girls will be a specific target group. The prevention of future high-risk pregnancies and the spacing of births will be highlighted. Problems related to AIDS will be addressed in an integrated fashion by training health workers to detect and refer suspected cases for diagnosis and care. Community-based home care will be promoted. The protection of health workers and other patients from infection by contaminated instruments, hands, etc., will be assured through the provision of adequate equipment (including gloves) to staff at risk and TBAs, with appropriate training in their use. Close cooperation will be maintained with the WHO-supported National AIDS Prevention and Control Programme.

35. The UCI objective is to reduce mortality and morbidity specifically through maintaining the coverage and improving the quality of the expanded programme on immunization, including tetanus toxoid vaccine for women, with a special emphasis on the elimination of neonatal tetanus and polio in this decade. Service quality will be improved through training and supervision, especially in those areas with poorer results, to ensure strict application of vaccine schedules and norms. Better use of staff in static units, including hospitals, through integrated training in PHC/UCI, will permit more vaccination sessions and greater availability of vaccines, thus reducing missed opportunities. Attention to the control and maintenance of the cold-chain system will assure vaccine efficiency through the service delivery level, while studies of vaccine efficacy are planned. Equipment and transport will be provided. The training of managers at district and health centre levels will ensure better supervision and training, adequate supplies, proper storage of vaccines and active monitoring of information for better management. Evaluation activities, periodic surveys and appropriate operations research will supplement routine data collection.

36. The objective of the CDD programme is to reduce mortality, morbidity and malnutrition caused by diarrhoeal diseases. Resource utilization will be improved through integrated training, supervision and monitoring for PHC/CDD. Training in the Diarrhoea Training Unit will target staff and managers. Better case management, including the face-to-face education of care-givers, will result from in-service training and the integration of CDD into PHC training and supervisory activities, with the establishment of ORT corners in all health facilities. Inter-agency coordination will result in better management of the ORS supply chain. Community education and mobilization will be strengthened and extended to include other PHC components. The prevention of diarrhoeal diseases through improved hygiene practices will form part of the educational message. Community-supported water and sanitation interventions will be promoted, especially in urban areas, building on the example of the neighbourhood mothers' project at Lusaka, where women volunteers have been trained to promote ORT and basic hygiene measures.

37. The objective for the nutrition programme is to reduce child mortality and morbidity and promote growth through early detection and correction of growth faltering, as well as early detection and rehabilitation of malnutrition. A decrease in malnutrition is sought through an integrated PHC approach to child health. Growth monitoring and promotion, with counselling and adequate case management as integral parts of PHC services, will be achieved through staff training and support. Training will help to reduce the high fatality rate in severely malnourished children. Face-to-face nutrition education by health staff will be strengthened and other channels will be used to influence community practices in key areas such as infant feeding. Intersectoral activities will be promoted to address identified nutrition problems in pilot areas through the utilization of the "Triple A" approach (continuous assessment, analysis and action). The training of child health workers and TBAs as front-line workers for screening and referral will be carefully evaluated, as experience to date has indicated problems in the areas of motivation and support. Vitamin A and iodine deficiency will be addressed

through the development of national strategies and support for implementation in affected areas.

38. Another project aims to develop replicable activities to strengthen PHC services and management in selected districts. Such activities will include locally based financing systems with greater community involvement in management. The quality of PHC will be improved through regular availability of drugs, increasing the motivation and skills of health workers and improved training and supervision. The services will include UCI, CDD, MCH, nutrition, malaria and acute respiratory infections. Management of PHC will be strengthened at the district level, particularly in planning, supervision and monitoring, by building on the existing district management team. Intersectoral linkages, training and exposure to other experiences will facilitate the use of approaches for identifying and solving problems with communities. Financial resources for PHC will be mobilized at the community level through the introduction and testing of community financing schemes. In line with decentralization policies, revenues will be retained at the facility level. The flow of resources from central to district level will also be streamlined, as will the management of district-level financing. These efforts will be supported by advocacy and related actions for increased government budgetary support to PHC. Community participation in PHC management will be promoted through education and mobilization in order to increase community understanding and the use of PHC services by building on existing community-financing mechanisms to increase local responsibility for locally generated revenues and by improving the capabilities and motivation of child health workers and TBAs to address community health needs. Learning from experience is essential for the introduction of alternative approaches to PHC management. Monitoring and evaluation will be complemented by operational research to identify effective service delivery and management approaches. Institutional linkages will be made to carry out research and provide training links with other innovative PHC activities.

39. With an emphasis on strengthening national expertise to ensure the overall long-term development of the PHC programme, collaboration will be encouraged among concerned organizations and institutions from the central to the community level. This should achieve clearer shared definitions of goals and objectives and more efficient resource utilization. Similarly, the effective integration in PHC planning and implementation will be supported, especially in key activities such as management and health information systems that will catalyse broader action and provide inputs relevant to national policy decisions. Support for the collection and utilization of appropriate information in order to learn from experience and try out new ideas will be reflected in all activities.

40. Because the socio-economic impact of the spread of AIDS and the implications for women and children are still not fully understood, the "children in distress" component will support research and data collection, as well as pilot operational activities in affected communities. The main problems to be addressed are the growing number of AIDS orphans (expected to exceed 100,000 within the duration of the programme) and of HIV infected

children, as well as the need to support families coping with the social, psychological and economic pressures of terminally ill family members. The scale of the problem requires the mobilization and strengthening of new partners, especially NGOs and community-based groups, through training, institutional support and exchanges of experience. A coalition of interested NGOs and community leaders is already starting activities at Lusaka. The project will be implemented within the framework of the WHO-supported National AIDS Prevention and Control Programme.

Education for All

41. The Government is in the process of defining a national strategy and plan, with the following goals for the year 2000: (a) to enrol all primary-school-age children in primary school or its equivalent; (b) to retain all primary-school-age children in school for the equivalent of seven grades; (c) to reduce the adult illiteracy rate to one half the present rate; (d) to reduce the female illiteracy rate to equal the male rate; and (e) to provide life skills training for youth and adults. Within this framework, this programme aims: (a) to increase the progression rate at the end of grade four in 1995 to 95 per cent of grade one intake in 1992; (b) to ensure that all 10-year-old children achieve or surpass competencies defined for grade four or its equivalent by the year 1995; (c) to reduce the adult illiteracy rate from 25 per cent in 1990 to 20 per cent in 1995; (d) to reduce the female illiteracy rate from 33 per cent in 1990 to 22 per cent in 1995; and (e) to focus learning activities on out-of-school youth, particularly 11 to 15 year olds.

42. The learning achievement component focuses on the development and production of learning materials. Support will be targeted to the most urgent needs, beginning with materials for primary schools that focus on life skills (using Facts For Life messages). Workbooks and selected supplementary readers will be produced in English and in four local languages for grades one to four. An Education for All magazine will also be produced to permit the exchange of information between schools and to narrow the gap between formal and non-formal education. NGOs, churches and other groups will be involved in informal learning activities to reach underserved groups. Innovative and cost-effective measures will also be developed to meet the shortfall in the provision of education facilities, especially for the most vulnerable. Such measures include intensification of the child-to-child approach, multi-grade teaching and tight timetabling. School community linkages will be strengthened through the Parent-Teacher Association movement. This will increase community participation in the education system in general, with particular attention to early childhood development. Intersectoral linkages will be reinforced and there will be greater complementarity between formal and non-formal education. In-service teacher training will reorient teachers to new methods of teaching and utilization of new materials. Improved assessment techniques will be developed to evaluate learning achievement. Attention will be drawn to educational disparities and deprivation through workshops and seminars, the mass media and studies on marginalized groups and on the impact of adjustment.

43. The component on learning opportunities, particularly for women and girls, will focus on demand-driven functional literacy that responds to the needs of women's groups, in particular, and out-of-school children and adolescents. In this process, post-literacy and informal learning opportunities and efforts to apply literacy skills to daily life and the social environment are important. Support to learners will be emphasized, thus enabling them to acquire basic literacy and numeracy skills, apply those skills to self-improvement and productive activities, and develop critical awareness of their situation. Recognizing the diverse needs of youth and adults, the project will develop a variety of delivery systems, including NGOs and churches. Linkages between formal and non-formal education, along with linkages with other development initiatives, will be strengthened. A particular effort will be made to involve local administrations in developing community participation and utilizing local resources and facilities. Learning material packages, beginning with life skills (using Facts For Life), will be produced in both English and local languages, and training will be provided for instructors, supervisors and other key staff.

Planning and social statistics

44. The project will strengthen the capacity for the analysis of social issues, supported by a system for monitoring social indicators at national, district and community levels, which can provide a reliable and timely flow of information. High priority will be given to monitoring progress towards the goals and strategies for children and development in the 1990s as endorsed by the World Summit for Children.

Community-based child survival and development

45. This programme aims: (a) to increase income and food security through training and access to information and credit; (b) to enhance early child development through community- and home-based child care; (c) to improve infant nutrition through the promotion of exclusive breast-feeding and improved weaning and supplementary feeding practices; (d) to improve environmental sanitation with protected water supplies, improved pit latrines and hygiene education; (e) to support site-specific adaptations of PHC and Education for All programmes; (f) to develop an effective and replicable methodology for sustainable community-based development; and (g) to develop district planning and management processes and a responsive service system supportive of community-based development.

46. The programme directly addresses the problems of poor urban and rural households, particularly those headed by women. It seeks to improve on past experience by changing the focus from small groups to communities through working more directly with district administration and community groups. Initially, the programme will select disadvantaged communities in the urban district of a secondary city and several rural districts in Luapula Province, which has a high proportion of households headed by women and the highest malnutrition rates in the country. An important feature is the development of district planning and implementation processes, which are supportive of

community-based development. This will include policy advocacy and orientation activities at all levels to encourage greater decentralization of health, education and social services. The district administration will be encouraged and supported to work directly with community-based organizations and to develop service systems that are responsive to felt needs in the community and supportive of community initiatives.

Advocacy

47. The programme will offer opportunities for advocacy for issues of global concern for children, including those not addressed by substantive programmes. The Government is preparing for the ratification of the Convention on the Rights of the Child. A study is being undertaken by leading Zambian lawyers on existing national legislation concerning children and on the process for incorporating the Convention into Zambian legislation. UNICEF will support research and sensitize decision makers on issues concerning women, the impact of adjustment on vulnerable groups, orphans, education (especially for girls) and the environment. Parliamentarians will be a key target group. The initial centrepiece for policy advocacy and action will be the development of a national programme of action for children based on the Declaration of the World Summit for Children.

Cooperation with the United Nations and other organizations

48. The programme has been developed in close cooperation with the United Nations system in order to strengthen coordination and enhance the complementarity of the inputs of the various agencies. Inter-agency cooperation will be strengthened, especially on cross-cutting issues such as adjustment, food and nutrition and women, with the partners of the Joint Consultative Group on Policy. WHO is cooperating closely in areas such as EPI, CDD, MCH, AIDS, district management and the Bamako Initiative. UNFPA is a close partner in MCH and family planning. Collaboration with the United Nations Educational, Scientific and Cultural Organization has been greatly reinforced by the Education for All initiative. Complementarity is being sought with the World Food Programme in the supplementary feeding of malnourished children in health centres. With the Food and Agriculture Organization of the United Nations and the International Labour Organisation, there is close cooperation on household food and income issues, including national food strategies, household food security, income generation and skills training. Key bilateral agencies such as the Swedish International Development Authority, the Norwegian Agency for International Development, the Finnish Agency for International Development, the Canadian International Development Agency, the Japan International Cooperation Agency, the Overseas Development Administration (United Kingdom), the United States Agency for International Development, Dutch Cooperation and the German Agency for Technical Cooperation, have participated in programme preparation to ensure close coordination and collaboration in programme delivery.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

Zambia (1989 and earlier years)			UNICEF country classification			
Under-five mortality rate	125	(1989)	High U5MR			
Infant mortality rate	78	(1989)	High IMR			
GNP per capita	\$ 290	(1988)	Low GNP			
Total population	8 million (1989)					
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT			1970	1980	1985	1989
Births	(thousands)		206	288	344	403
Infant deaths (under 1)	(thousands)		22	26	29	31
Under-five deaths	(thousands)		35	42	46	50
Under-five mortality rate			172	146	135	125
(per 1,000 live births)						
Infant mortality rate (under 1)			108	91	84	78
(per 1,000 live births)						
			About 1980	Most recent		
Underweight children (under 5)	Moderate & severe		..	25*		
(% weight for age, 1980/1990)	Severe		..	5*		
Babies with low birth weight			14	..		
(%, 1971-1972/1987)						
Children completing primary level			85	91		
(% of first grade, 1980/1986)						
NUTRITION INDICATORS			About 1980	Most recent		
Mothers breast-feeding at 3/6/12 months			/..	/ 93*		
(%, 1980/1985)						
Prevalence of wasting (%, 1980/1990)			..	10*		
Prevalence of stunting (%, 1980/1990)			..	59*		
Daily per capita calorie supply			95	92		
(% of requirements, 1979-1981/1984-1986)			103	96		
Food production per capita index						
(Index 1979-1981=100, 1980/1989)						
Household expenditure	All food/cereals			37/ 8		
(% of total income, 1980-1985)						
HEALTH INDICATORS			About 1980	Most recent		
ORT use rate (%, 1987-1988)				59		
Access to health services	Total		..	75		
(% of population, 1980/1983)	Urban/rural		../..	100/50		
Access to safe water	Total		..	59		
(% of population, 1980/1985)	Urban/rural		../..	76/41		
Access to adequate sanitation	Total		..	56		
(% of population, 1980/1985)	Urban/rural		../..	76/34		
Births attended by trained personnel			..	39*		
(%, 1980/1986)						
Maternal mortality rate				150		
(per 100,000 live births, 1979/1983)			..			
Immunization			1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis		72	..	92	..
	DPT		44	..	83	..
	Polio		77	..	81	..
	Measles		21	..	80	..
Pregnant women (%) immunized against	Tetanus		..	..	..	..

TABLE 1 (continued)

Zambia

EDUCATION INDICATORS		About 1980		Most recent	
Primary enrolment ratio (gross/net) (%, 1980/1986)	Total	98/ 84		97/ ..	
	Male	103/ 86		102/ ..	
	Female	92/ 81		92/ ..	
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	17/ ..		.. / ..	
	Male	22/ ..		.. / ..	
	Female	12/ ..		.. / ..	
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	52		67	
	Male/female	66/ 37		77/ 59	
Radio/television sets (per 1,000 population, 1980/1988)		.. / 13		74/ 15	

DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	4.2	5.7	7.0	8.1	12.3
Population aged 0-15 years	(millions)	..	3.0	3.6	4.2	6.3
Population aged 0-4 years	(millions)	..	1.1	1.4	1.7	2.4
Urban population (% of total)		30	40	45	49	59
Life expectancy at birth (years)	Total	46	50	52	54	59
	Male	45	49	51	53	57
	Female	48	52	54	55	60
Total fertility rate		6.8	7.2	7.2	7.2	6.6
Crude birth rate (per 1,000 population)		49	51	51	51	46
Crude death rate (per 1,000 population)		19	16	14	13	10

		About 1980		Most recent	
Contraceptive prevalence rate (%, 1977/1987)		1		..	
Population annual growth rate (%, 1965-1980/1980-1989)	Total	3.1		3.9	
	Urban	7.1		6.3	

ECONOMIC INDICATORS		About 1980		Most recent	
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		-1.2		-4.9	
Inflation rate (%, 1965-1980/1980-1988)		6		34	
Population in absolute poverty (%, 1977/1988)	Urban/rural	.. / ..		25/ ..	
Household income share (%, 1976/1988)	Top 20%/bottom 40%	61/ 11		.. / ..	
Government expenditure (% of total expenditure, 1980/1987)	Health/education	6/ 11		5/ 8	
	Defence	..		..	
	Health/education	..		5/ 6	
Household expenditure (% of total income, 1980-1985)					
Official development assistance: (1980/1988)	\$US millions	318		477	
	As % of GNP	10		22	
Debt service (% of goods & services exports, 1980/1988)		18		14	

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: ZAMBIA

LATEST BOARD APPROVAL: 1987

GENERAL RESOURCES: \$2,950,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	1083	4463	172	145	360	584	360	964	1975	6156	8131
Water supply and sanitation		1								1	1
Nutrition	145	46	46		5		36		232	46	278
Education	106		55		17		62		240		240
Community organization and development	189	152	40	9	2	46	41	55	272	262	534
Women-centred programme	5		12				19		36		36
Children in especially difficult circumstances		16								16	16
Emergency		45								45	45
Planning and project support	47		1		63	27	179	57	290	84	374
Freight	87	523							87	523	610
GRAND TOTAL	1662	5246	326	154	447	657	697	1076	3132	7133	10265

GR = General resources.

FSF = Funded supplementary funding.

/...

TABLE 3. PLANNED EXPENDITURE, 1991-1995

(In thousands of United States dollars)

Country: ZAMBIA Period covered: 1991-1995	Funding status	1991	1992	1993	1994	1995	Total
Health	GR	690	662	660	658	640	3310
	FSF	1785					1785
	NSF	2223	2757	2446	2208	2066	11700
Education	GR	375	370	368	368	359	1840
	NSF	1400	1500	1700	1700	1200	7500
Planning and social statistics	GR	122	140	149	151	173	735
Integrated area-based programme	GR	285	300	295	295	300	1475
	FSF	98					98
	NSF	400	425	465	490	505	2285
TOTAL	GR	1472	1472	1472	1472	1472	7360
	FSF	1883					1883
	NSF	4023	4682	4611	4398	3771	21485
GRAND TOTAL		7378	6154	6083	5870	5243	30728

GR = General resources.

NSF = New supplementary funding.

FSF = Funded supplementary funding.

/...

TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: ZAMBIA	Number of posts	Amount (thousands of United States dollars)

FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	3	673
Local national Professional and General Service established posts	14	311
Operating costs		537

Total	17	1521

FINANCED FROM PROGRAMME FUNDS: a/		
International Professional project posts		
General resources	5	1036
Supplementary funds	1	203
Local national Professional and General Service project posts		
General resources	17	346
Supplementary funds	5	102

Total	28	1687

a/ For information source, see 1992 post authorization table, dated January 1991.



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1991 session

FOR ACTION

COUNTRY PROGRAMME RECOMMENDATION*

Zimbabwe

The Executive Director recommends that the Executive Board approve the country programme of Zimbabwe for the period 1992-1996 in the amount of \$6,000,000 from general resources, subject to the availability of funds, and an amount of \$6,500,000 in supplementary funds, subject to the availability of specific-purpose contributions.

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3. Planned expenditure, 1992-1996	17
4. Staffing from budget and programme funds	18

* In order to meet documentation deadlines, the present document was prepared before aggregate financial data were finalized. Final adjustments, taking into account unspent balances of programme cooperation at the end of 1990, will be contained in the "Summary of 1991 recommendations for general resources and supplementary funding programmes" (E/ICEF/1991/P/L.2).

THE SITUATION OF CHILDREN AND WOMEN

1. Since the economic boom of the early 1980s, the economy of Zimbabwe has been negatively affected by drought, the lack of private sector investment, unfavourable terms of trade, the displacement of labour through capital-intensive production and the lack of expansion in the productive sector. Real incomes and household consumption have remained static or have declined. Women - because of their low education levels and lack of integration - have low rates of employment in the formal sector. They hold the most economically insecure jobs and are underpaid. Child labour persists, to the detriment of children.

2. Destabilization activities by the Mozambican National Resistance Movement have necessitated continued strengthening of national security and protection of the trade route through Mozambique, with major consequences on the national budget. Mozambican refugees in Zimbabwe, fleeing Resistance Movement aggression and drought, now number about 180,000, 61 per cent of them women and young children; about half of the refugees have been integrated into communities along the border. Despite these problems, however, Zimbabwe continues to provide a good environment for child survival, protection and development programmes. The country has a parliamentarians/media committee on child survival, protection and development and a Child Survival and Development Foundation.

3. The 1980s witnessed substantial expansion in health facilities in rural areas (three quarters of the population is rural peasantry), in the training of health care workers and in the coverage of primary health care (PHC) activities. Nevertheless, access to and use of health care is still hampered by inequalities in the health system, exacerbated by the concentration of resources in the private sector, poor functioning of the referral system, limited use of PHC among the poorest households and limited expansion of health care to large-scale commercial farming areas, where the poorest peasant sector is concentrated. Universal child immunization (UCI) was achieved in 1988, pre-natal care coverage involves 90 per cent of pregnancies and health facility delivery rates are 64 and 92 per cent in rural and urban areas, respectively. The maternal mortality rate (MMR) dropped from 145 per 100,000 live births in 1980 to about 90 per 100,000 in 1987. The infant mortality rate (IMR) and the under-five mortality rate (U5MR) both declined significantly from early 1980, to 83 and 75 per 1,000 live births, respectively, in 1990.

4. Infection with the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) threatens to erode previous gains in the reduction of morbidity and mortality, to deprive children of parental care and to increase their socio-psychological and economic problems. Ministry of Health statistics show that 25 per cent of HIV-related morbidity is among children under 5 years of age, and 57 per cent is among young adults 20 to 40 years of age. The 1988 demographic survey revealed that child undernutrition, at levels ranging from 10 to 30 per cent, continues to underlie the incidence, severity and case fatality of childhood diseases,

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particularly in children from one to five years of age. In rural areas, 11 to 22 per cent of children under five years of age live below the poverty line, compared with 2 to 6 per cent in urban areas. Nationally, in 1987, the average rate of low birth-weight caused by maternal undernutrition and poor foetal development was reported at 5.1 per cent, ranging from 1.6 per cent in a high density peri-urban area to 7.9 per cent in a rural area. These rates are low compared with the 10 to 11 per cent that some surveys report in urban areas.

5. The Government allocates substantial resources to education, the largest single item in the national budget. As a result, the number of primary schools has increased by 88 per cent, nearly doubling and tripling male and female enrolments, respectively, since independence. Secondary schooling has similarly expanded, with a sevenfold increase in the number of schools and a tenfold increase in enrolment. However, inflation and the introduction of school levies have reduced the ability of parents to maintain children at school. The drop-out rate has increased, with higher rates among girls and children from poorer households. Early childhood development activities have expanded, but facilities are inadequate, expensive for the poor, and staff are inadequately trained.

6. Substantial investment has been made in improving rural living conditions, particularly in the construction of ventilated improved pit (VIP) latrines and the development of safe water supplies. However, conditions in large-scale commercial farming areas continue to be poor, with no security of tenure for workers and their families, and little investment to improve social services. Economic developments have eroded the food and socio-economic security of wage earners and temporary labour on large-scale farms, of peasant households without adequate land or wage remittances and of households with below-poverty-level incomes.

PROGRAMME COOPERATION, 1987-1991

Primary health care

7. This integrated programme of maternal and child health (MCH) focused on the training of traditional midwives and village health workers (VHWs), the upgrading of rural health centres and clinics, the control of diarrhoeal diseases (CDD) and acute respiratory infections (ARI), the expanded programme on immunization (EPI) and the strengthening of the national health information system.

8. By the end of 1989, 80 per cent of rural health centres and clinics had trained over 17,000 traditional midwives. About 600 nurse midwives were also trained as trainers of traditional midwives. The project also prepared trainers to conduct pre-service and refresher courses for health workers, and produced training materials. The mid-term review revealed that, by the end of 1987, 1,250 VHWs had been trained (only a fraction of those planned), and 1,600 training kits and 1,000 bicycles had been provided. From 1987 to 1989, 43 new rural health centres were equipped and the health education unit was strengthened.

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9. The CDD project objective was to teach mothers how to prevent, manage and treat diarrhoeal diseases, thus reducing diarrhoea-related morbidity and mortality. It was largely achieved, with improvements in the knowledge, management and use of sugar and salt solutions by mothers; reductions in severe dehydration among children suffering from diarrhoea and attending clinics; and reductions in the use of intravenous therapy and anti-diarrhoeal medicines. An oral rehydration therapy (ORT) training unit was established. The Ministry of Health will now undertake local packaging of full formula oral rehydration salts (ORS) for distribution to rural health centres and the community, while continuing with studies on a maize porridge formula. By 1989, the ARI programme was established in all districts as an integral part of PHC, prevention and management workshops were conducted and community education materials produced. Case assessment and management charts, as well as a manual were also produced and used.

10. The EPI project objective, to make immunization available to all infants and pregnant women through strengthening the delivery system, increasing awareness of EPI and carefully monitoring implementation and effectiveness of immunizations, was largely achieved in 1988. About 80 per cent coverage, antigen by antigen, was recorded among children aged 12 to 23 months. Fully immunized coverage was 79 per cent. Coverage of pregnant women with two doses of tetanus toxoid vaccine was 54 per cent in 1989. One of the major achievements of the national health information system was the establishment of a disease surveillance system for neonatal tetanus, measles and polio myelitis, a prerequisite for eradicating these diseases. The Statistics Unit of the Ministry of Health was strengthened, a manual on the health information system was produced and the posts of national coordinator and provincial statisticians were established. The project, however, lacks equipment and adequate staffing at the district level.

Nutrition

11. As part of policy development, a multisectoral approach to nutritional issues was adopted, with major emphasis on food accessibility at the household level, and preparations for a food and nutrition policy were started. Growth monitoring continued, as did the promotion of breast-feeding, with 1989 coverage at 95, 82 and 52 per cent at 6, 12 and 18 months, respectively. A survey of iodine deficiency disorders (IDD) was conducted and a national committee on the control of IDD was formed.

Water supply and environmental sanitation

12. The technology to sink deep wells was successfully demonstrated and guidelines were developed. A water division training unit was established, training programmes were developed and three technical manuals were completed. Once supervisors were trained and water committees established, the construction of 165 wells was undertaken (in excess of the target of 150), and 107 wells were upgraded, for which pump-minders, district extension officers and caretakers were trained and equipped. The rural sanitation project successfully trained 151 unemployed youths by 1989 as latrine

builders, and about 1,634 latrines were constructed, more than 50 per cent above target. With a research institute, a study on a simple device to facilitate hand washing after latrine use was undertaken. Major constraints included the difficulties of supervising a project spread over three distant districts, initial resistance by communities to construct unfamiliar structures and scarcity of cement.

Basic education

13. The objectives were to promote child-centred learning through the effective use of curriculum materials and the training of teachers. Some 42 titles on family life and nutrition education were produced. About 20,000 copies of a booklet on the design and production of learning aids and devices were produced and about 2,000 education officers and 345 teachers were trained in its use. About 22,600 copies of nutrition text books and teachers' guides were also produced. About 1,280 headmasters underwent a one-week course in effective curriculum and pedagogic approaches to child-centred learning. Some 40 lecturers and education officers involved in student-teacher supervision and the production of distance education modules attended a national orientation workshop, and 900 college lecturers, headmasters, education officers and teachers attended regional workshops. Activities were undertaken to develop a national literacy and post-literacy programme encompassing PHC, agriculture and education elements. The community and women's education component aimed at training ward community coordinators to assist village community workers, who would then help villagers to identify needs and undertake projects in health, sanitation, rural enterprises, food production and nutrition. Over 75,000 illiterates were enrolled, and two courses for 71 district coordinators were conducted. A provincial literacy writers' workshop produced 22 manuscripts, of which eight were printed. About 12,000 Shona and Ndebele primers, 1,120 Shona and Ndebele tutors' guides and 22,000 numeracy primers and tutors' guides were produced.

National household survey programme

14. The objective was to help train staff and establish an adequate capacity for the timely processing, analysis and dissemination of data for planning socio-economic sector programmes and to establish a system for monitoring social development programmes. Surveys on literacy, labour force, income consumption and expenditure, demography and health and agriculture and livestock were all completed with the assistance of UNICEF and other agencies.

Mozambican refugees

15. The programme covered PHC services, sanitation, water supply, education, skills training for women, adult literacy and pre-school education. Problems of inadequate health services, malnutrition, poor sanitation and high illiteracy rates among children and women in refugee camps have not been adequately addressed owing to financial limitations, with only 15 per cent of the required supplementary funding available.

RECOMMENDED PROGRAMME COOPERATION, 1992-1996

Recommended general resources: \$6,000,000

Supplementary funds: \$6,500,000

Recommended programme cooperation a/

(In thousands of United States dollars)

	<u>General resources</u>	<u>Supplementary funds b/</u>	<u>Total</u>
Primary health care and nutrition	1 250	1 700	2 950
Water supply, sanitation and hygiene	1 000	1 500	2 500
Women in development	800	750	1 550
Education	1 750	1 300	3 050
Communications and advocacy	250	250	500
Planning and social statistics	250	-	250
Programme support	700	-	700
Mozambican refugees	-	1 000	1 000
Total	<u>6 000</u>	<u>6 500</u>	<u>12 500</u>

a/ The breakdown for estimated yearly expenditures is given in table 3.

b/ In addition, there are also funded supplementary funding projects shown in table 3.

16. The proposed country programme focuses on health and nutrition, water supply and sanitation, support to women and basic education. These are supported by a programme to strengthen planning and social statistics and a programme for social mobilization. Mozambican refugees will continue to receive assistance. Most support will go towards national programmes, with a focus on strengthening national capacity to mobilize, plan and deliver services and to achieve sustainability. Special emphasis will be placed on mobilizing rural communities and assisting them in identifying problems, planning how to solve them and providing key inputs for implementing and monitoring selected major activities. To this end, the establishment of area-based activities in selected rural communities, especially in large-scale commercial farming areas, will be explored.

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Health and nutrition

17. The objectives include reducing, by 1996, MMR from the 1990 level of 90 to 75 per 100,000 live births; perinatal mortality from the 1990 level of 30 to 25 per 1,000 live births; IMR from the 1990 level of 53 to 44 per 1,000 live births; and U5MR from the 1990 level of 75 to 63 per 1,000 live births. In addition, the programme aims to reduce (a) tuberculosis incidence among children under five years of age by at least 50 per cent of the 1990 level; (b) mortality caused by measles by at least 50 per cent of the 1990 level; (c) mortality from pertussis by at least 50 per cent of the 1990 level; (d) morbidity and disability from polio myelitis by 100 per cent of the 1990 level; and (e) neonatal mortality by at least 50 per cent of the 1990 level. The reported diarrhoea case fatality rate in children under 11 months is to be reduced from the 1990 level of 5.6 to 2.8 per cent, and the unreported under-five case fatality rate associated with diarrhoea case mismanagement in communities and rural health centres is to be reduced from 15 to 7.5 per cent.

Safe motherhood

18. The objectives are: (a) to promote early registration for pre-natal care, at 12 weeks of pregnancy, and a minimum of four pre-natal-care visits by 90 per cent of pregnant women; (b) to have 90 per cent of all deliveries supervised by a trained health worker; (c) to increase the proportion of home deliveries assisted by trained traditional midwives from the 1990 level of 30 per cent to 45 per cent, especially in commercial farming areas; and (d) to increase the proportion of women receiving post-natal care six to eight weeks following a home delivery from the 1990 level of 40 per cent to 80 per cent by 1996. Obstetric equipment will be supplied to rural health centres not covered by the family health project. Staff will be trained to improve the management of deliveries and care of the newborn to reduce referrals. A community education programme involving health personnel, village community workers, adult literacy classes and social mobilization will improve women's awareness about poor perinatal health status and how to improve it. Village community workers and traditional midwives will mobilize pregnant women for early and regular pre-natal visits. Studies will be undertaken to explore cultural beliefs relating to early pre-natal care and to design appropriate measures. For effective monitoring of MCH activities (especially tetanus toxoid immunization status), the Ministry of Health will give mothers' cards to all women of child-bearing age and hold workshops on their use. Training to upgrade traditional midwives will be supported by the family health project.

19. Programmes for women and families at risk of AIDS and non-governmental organizations (NGOs) such as the Women's AIDS Support Network, Zimbabwe AIDS Control Programme and the Paediatrics Department of the University of Zimbabwe will be supported. The Health Education Unit of the Ministry of Health will be assisted in producing HIV/AIDS health education materials targeted at pregnant women attending MCH clinics. In collaboration with the Curriculum Development Unit, the development and production of family life education materials for the in-service training of teachers will be assisted. Messages on the prevention of sexually transmitted diseases (STDs), including HIV/AIDS,

will be incorporated into the teacher-training syllabus so that teachers can impart this information to their students. Support will be provided for in-service training of district workers in the counselling skills necessary for successful implementation of community or home-based HIV/AIDS care, including care of AIDS orphans and potential AIDS orphans.

Expanded programme on immunization

20. The objectives are to achieve and sustain infant immunization coverage of 98 per cent for tuberculosis, 90 per cent for measles, 90 per cent for diphtheria/pertussis/tetanus, 90 per cent for polio myelitis and 75 per cent coverage for tetanus among women of child-bearing age by 1996. From 1992, the family health project will provide logistics support for outreach services. Since the cold chain is adequate, only buffer stock replacements and repair tool kits for all districts will be provided. Equipment to sterilize syringes and needles will be provided for new rural health centres. The Ministry of Health plans to assume gradually responsibility for the purchase of vaccines. Personnel development, including workshops for mid-level managers, community workers and cold-chain technicians will be supported with technical assistance from the World Health Organization (WHO). EPI sustainability will be enhanced by the Governments undertaking to provide child health cards that were previously provided by UNICEF. UNICEF and WHO will continue to support Ministry plans to accelerate the vaccination of all women of child-bearing age. An EPI coverage survey is planned for 1990, and major health reviews will take place in 1992 and 1994.

Control of diarrhoeal diseases and acute respiratory infections

21. The objectives include strengthening CDD district training units, increasing children's access to ORT and improving the training of staff in ORT. While a CDD advisory committee examines the issue of full formula ORS, the Health Education Unit will be assisted in intensifying its efforts to prevent diarrhoea, with an emphasis on breast-feeding; frequent administration of fluids during diarrhoea; hygiene education, including the promotion of VIP latrine construction; and the use of protected water sources. ARI is the major cause of reported child morbidity and mortality. The underlying causes are related to poverty and include poor ventilation. UNICEF, therefore, will assist with the production of flip charts in local languages to discourage harmful practices in the home management of ARI. District training units will provide training both in CDD and ARI to village community workers and others. In collaboration with the National Health Information System and Central Statistics Office, they will also be responsible for programme monitoring and evaluation.

Food and nutrition

22. The objectives of the national nutrition surveillance system are to establish an institutional food and nutrition surveillance system that will effectively monitor and evaluate the nutritional situation of children; to establish a community-based growth monitoring programme in at least one

district; and to ensure that by 1996, 90 per cent of children, by their second year of life, are regularly monitored for growth four times a year, an increase from twice a year in 1988. These objectives will be achieved by incorporating appropriate nutrition indicators into the food early warning system; developing educational materials and promoting their use at the community level; supporting training programmes for health personnel; using growth monitoring data at the community level to plan and develop nutrition projects; and providing supplies and equipment for community-based growth monitoring. The objectives of the infant and child feeding project are to promote exclusive breast-feeding during the first four months of life and to reduce the percentage of mothers who stop breast-feeding completely when a child has diarrhoea. Close collaboration with provincial and district food and nutrition management teams will be maintained to achieve these goals. Social mobilization at all levels will be supported and extension staff will be trained on better child feeding practices.

National health information system

23. The system will ensure that health information needed for planning, management, monitoring, evaluation and research is available at all levels. At the rural health centre level, village community workers, traditional midwives and similar cadres report on all health delivery activities in the catchment area. These data are well analysed and used at the national level, but training workshops and supervisory visits will need to be organized to ensure that all levels develop the skills necessary to analyse and use data.

24. The health and nutrition programme will be monitored by MCH coordinators at national, provincial and district levels, and at the community level, by rural health centre staff (or health committees in the commercial farming areas). Monitoring and evaluation will consist of routine reporting; sentinel surveillance; disease-specific morbidity, mortality and treatment surveys; annual district health reports; and a comprehensive programme review in 1994. Quarterly and annual programme reviews will be conducted, and in collaboration with the Ministry of Education and Culture, an impact evaluation of schools' PHC competitions will be undertaken.

Communication and health education

25. Communication and health education activities will be supported, including annual health awareness weeks and the development and promotion of materials on child-feeding practices and nutrition during pregnancy. To determine what health education materials need to be reproduced and updated, existing materials will be inventoried.

Water supply and sanitation programme

26. The programme will ensure that safe water supply and excreta disposal are accessible to people in selected communities and promote hygiene education. Programme objectives to be achieved by 1996 are: (a) to reduce the percentage of faulty public hand-pumps from an estimated 20 per cent in 1990 to an

average of less than 5 per cent; (b) to increase the percentage of households with VIP latrines in communal farming areas from 25 per cent in 1990 to 45 per cent; and (c) in at least 40 districts, to increase to 90 per cent the proportion of women of child-bearing age who have a minimum level of knowledge of safe hygiene practices. It is anticipated that 1.1 million women of child-bearing age will attain a minimum level of hygiene knowledge and, overall, 5.5 million people will benefit. Each district will identify an environmental health technician to be trained in participatory education techniques and to be responsible for hygiene education.

27. Baseline surveys will be conducted by provincial health education staff to identify poor hygiene behaviours and appropriate health education packages will be developed. Using the packages, workshops will be conducted at the interministerial provincial, district and ward levels for water and sanitation personnel on better hygiene practices, team building, participatory education, management and technical education. Workshops will also be organized for ward health committees on management, planning, training and evaluation techniques. The ward health teams will organize courses explaining the role of water point committees to village development committee members, village community workers, traditional midwives and local leaders. These community figures will then select and train water point committees, who will have responsibilities such as maintaining pumps and educating families about hygiene. To monitor and evaluate this programme, quarterly and annual reviews will be conducted, a national hygiene education symposium will be held every two years and a health impact evaluation will be conducted in 1994.

Women's programme

28. The entire country programme deals with gender issues. The women's programme will focus specifically on improving women's status and their opportunities for entrepreneurial activity in rural and high density urban areas. The objective is to increase their access to credit and appropriate technology, through information dissemination and development of marketing facilities. The Ministry of Community and Cooperative Development and the Department of Women's Affairs will jointly support programme activities. For sustainability, the programme will build on, support and extend existing initiatives for women. Workshops on awareness-building will be held at provincial, district, ward and village levels for women to identify their problems and ways to solve them. Training materials will be prepared based on national, regional and local resources. Training and skills development of extension cadres for support to women entrepreneurs will be undertaken at community level and will cover techniques for assessing potential entrepreneurs and viable projects.

29. The development and production of appropriate manuals and training materials to enable women to identify and analyse economically viable investment opportunities within their communities will be assisted. Support will be made available for the improvement of training and skills development of the extension staff of the Ministry of Community and Cooperative Development and representatives of the Department of Women's Affairs, in close

collaboration with the International Labour Organisation, the World Bank and the United Nations Development Fund for Women. In the first year of the programme, extensive project preparations will be made.

Basic education

30. Building on government achievements in education, and in line with the Jomtien Declaration on Education For All, the programme will concentrate government, community and NGO resources to provide basic education for all, with priority for children and women in the rural areas. The overall objectives include the establishment of a national early childhood development system, with special emphasis on rural areas; elimination of illiteracy by the year 2000; finalization of a curriculum that promotes productive values, skills and knowledge, and empowers children and women to participate effectively in life; and preparation of well-trained teachers, who will contribute to community life and development efforts. The programme will be implemented by the Government, in close collaboration with extension workers in relevant NGOs and church organizations.

Curriculum development

31. The objectives are (a) to improve the quality of education by promoting a stimulating learning environment at home and in the school; (b) to improve the health of the child by disseminating knowledge and skills on health, nutrition and family life; and (c) to enrich the role of women in society by involving mothers in health, nutrition and family life education. Project activities will include family life education to teach children how to avoid teenage pregnancy and STDs, especially AIDS, and will emphasize school/home cooperation to create an environment conducive to learning. Children will also be encouraged to take responsibility for themselves, their peers and siblings in areas of health, nutrition and general education. Teachers will be assisted in making low-cost effective learning and teaching aids. Home economics classes will provide knowledge and skills on food, nutrition, home maintenance, health and safety. Reading materials for children in disadvantaged areas will also be provided.

32. These sub-components will be implemented in close collaboration with the Ministries of Education and Culture, Higher Education, Health and Community and Cooperative Development, and with NGOs. Emphasis will be placed on the provision of relevant materials and the orientation of education officers, school heads and teachers during national, regional and district workshops. Manuals and other educational materials will be reproduced and distributed, and support will be provided for the minimal logistics necessary for supervision, monitoring and evaluation.

Teacher education

33. The objective is to improve the quality of education through the reduction of the teacher-student ratio, the preparation of well-trained teachers and quality instructional and distance education materials, improved

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monitoring and supervision and periodic evaluations. Activities will follow a multifaceted research study involving the implementing organizations. Workshops will be organized covering administration and leadership, distance education, supervision and evaluation techniques, and modules will be produced and printed during writing sessions every term. Each school holiday, in-service courses for underqualified teachers will be conducted. This component will be evaluated every two years.

Adult literacy

34. Following the Jomtien declaration, Zimbabwe has embarked on an aggressive adult literacy and basic education programme with the following objectives: (a) mobilizing and enrolling about 250,000 illiterate adults (85 per cent of them women) for literacy classes every year; (b) training about 5,000 new literacy tutors; (c) organizing teachers' and supervisors' workshops in each district on how adults learn and the best way to teach them; (d) improving project organization and supervision by training 110 district literacy coordinators; and (e) increasing available educational materials by organizing workshops for material development, and reviewing and reprinting literacy and numeracy books. Each primary school will appoint a teacher to be responsible for adult literacy and mass education activities, mobilize people and establish classes of at least 20 illiterates per year. Companies, parastatals and other large employers will also participate by providing physical facilities, allowing time for classes at work and providing remuneration for tutors and mass organizations, including the ruling party, will mobilize people and monitor progress. The Government will meet the biggest share of implementation costs and solicit support from other donors. UNICEF resources will be utilized to conduct workshops for 55 literacy teachers per year, to develop and produce educational materials, to provide logistics support and to assist an annual evaluation exercise.

Early childhood development

35. The objectives are to provide young children with a solid educational foundation by concentrating on all aspects of child development; to provide health care and hygiene education for children; and to introduce a stimulating and caring environment that enables children to learn and develop through play. Support will be provided to create awareness about early childhood development to 1,200 district education officers and headmasters; to develop a limited number of early childhood development centres next to teacher-training colleges; to develop and produce early childhood development books; to strengthen supervisory capacity through logistics support; and to monitor and evaluate the programme, with a major review to be held in 1994.

Mozambique refugee programme

36. Following a needs assessment mission, this programme will support: (a) the reduction of infant and child morbidity and mortality resulting from inadequate PHC services, poor nutrition and lack of hygiene education; (b) basic education activities for children; (c) literacy activities to teach refugees basic reading, writing and numeracy skills in their own language so

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they can benefit from basic child survival, protection and development information; and (d) basic care and stimulation of young children, thus contributing to their socialization and development.

37. The PHC component will assist the Office of the United Nations High Commissioner for Refugees (UNHCR) in improving children's health and nutrition by strengthening established health services; transporting patients referred to hospital; strengthening the cold chain; supporting the training of village community workers and traditional midwives; providing educational materials on safe delivery and better hygiene; and constructing an estimated 1,500 VIP latrines. Preventing the transmission of malaria, hyperendemic in Mozambique, will be a focus, as will treating children and women suffering from it. In primary education, health, nutrition and family life education topics will continue to be incorporated into the curriculum, supported by educational materials obtained from Mozambique. The training of Mozambican literacy tutors will continue, and at least two pre-school teachers for each pre-school will be trained. Support will be provided through the Ministry of Health, the United Nations High Commissioner for Refugees and UNHCR, and close collaboration with NGOs will be maintained at the field level. To monitor implementation, quarterly visits to refugee camps will be undertaken and a major review will be conducted in 1994.

Planning and social statistics

38. The objective is the timely provision of quality data for planning purposes. Major activities will include surveys on health and nutrition, health actions and utilization of services, and income, consumption and expenditure. Staff training, the mid-term review in 1994 and impact evaluations of sectoral programmes will also be supported.

Social mobilization programme

39. The objectives are to elicit the commitment of the Government, NGOs and individuals to policies and programmes to improve the lives of children and women; to advocate for disadvantaged children and women; to encourage communities to engage in activities that contribute to the development of children and women; and to increase people's awareness of children's and women's problems. Activities will be targetted to mass organizations and to all media, channelled through radio and television, as well as through articles in papers and magazines. Workshops based on Facts For Life will be organized at various levels and copies of Facts For Life in local languages will be distributed widely. The development of information and educational materials based on Facts For Life will be supported and effective community change agents will be identified. Measurable indicators for monitoring and evaluation will be determined and a knowledge, attitude and practice survey will be conducted in 1994 to assess progress.

TABLE 1. BASIC STATISTICS ON CHILDREN AND WOMEN

<u>Zimbabwe</u> (1989 and earlier years)			<u>UNICEF country classification</u>		
Under-five mortality rate	90	(1989)	High USMR		
Infant mortality rate	63	(1989)	High IMR		
GNP per capita	\$ 650	(1988)	Lower-middle GNP		
Total population	9 million	(1989)			
KEY INDICATORS FOR CHILD SURVIVAL AND DEVELOPMENT		1970	1980	1985	1989
Births	(thousands)	262	301	342	380
Infant deaths (under 1)	(thousands)	25	24	24	24
Under-five deaths	(thousands)	40	35	41	34
Under-five mortality rate		154	116	121	90
(per 1,000 live births)					
Infant mortality rate (under 1)		97	81	71	63
(per 1,000 live births)					
		About 1980		Most recent	
Underweight children (under 5)	Moderate & severe	..		12a/	
(% weight for age, 1980/1988)	Severe	..		2a/	
Babies with low birth weight		15		..	
(%, 1979/1987)					
Children completing primary level		..		74	
(% of first grade, 1980/1986)					
NUTRITION INDICATORS		About 1980		Most recent	
Mothers breast-feeding at 3/6/12 months		.. / .. / ..		98/ 96/ 84	
(%, 1980/1985)					
Prevalence of wasting (%, 1980/1988)		..		2b/	
Prevalence of stunting (%, 1980/1988)		..		31c/	
Daily per capita calorie supply					
(% of requirements, 1979-1981/1984-1986)		90		89	
Food production per capita index		91		94	
(Index 1979-1981=100, 1980/1989)					
Household expenditure	All food/cereals			40/ 9	
(% of total income, 1980-1985)					
HEALTH INDICATORS		About 1980		Most recent	
ORT use rate (%, 1987-1988)				26	
Access to health services	Total	..		71	
(% of population, 1980/1987)	Urban/rural	.. / ..		100/62	
Access to safe water	Total	52a		..	
(% of population, 1980/1987)	Urban/rural	.. / ..		.. / 32	
Access to adequate sanitation	Total	..		..	
(% of population, 1980/1987)	Urban/rural	.. / ..		.. / 15	
Births attended by trained personnel		37		69	
(%, 1980/19847)					
Maternal mortality rate					
(per 100,000 live births, 1979/1987)		480		..	
Immunization		1981	1985	1988	1989
One-year-olds (%) immunized against:	Tuberculosis	64	76	89	82
	DPT	39	63	79	79
	Polio	38	63	79	79
	Measles	56	53	75	75
Pregnant women (%) immunized against	Tetanus	..	40	22	54

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TABLE 1 (continued)

Zimbabwe

EDUCATION INDICATORS		About 1980		Most recent		
Primary enrolment ratio (gross/net) (%, 1980/1988)	Total	88/ ..		128/ ..		
	Male	.. / ..		130/ ..		
	Female	.. / ..		126/ ..		
Secondary enrolment ratio (gross/net) (%, 1980/1988)	Total	8/ ..		51/ ..		
	Male	.. / ..		60/ ..		
	Female	.. / ..		42/ ..		
Adult literacy rate, 15 years & older (%, 1970/1985)	Total	55		62		
	Male/female	63/ 47		70/ 55		
Radio/television sets (per 1,000 population, 1980/1988)		.. / 21		85/ 22		
DEMOGRAPHIC INDICATORS		1970	1980	1985	1989	2000**
Total population	(millions)	5.3	7.1	8.3	9.4	13.1
Population aged 0-15 years	(millions)	..	3.6	6.0	4.5	6.0
Population aged 0-4 years	(millions)	..	1.3	1.5	1.7	2.1
Urban population (% of total)		17	22	25	27	35
Life expectancy at birth. (years)	Total	50	55	57	59	64
	Male	49	53	55	57	63
	Female	52	57	59	61	66
Total fertility rate		7.4	6.4	6.0	5.7	4.6
Crude birth rate (per 1,000 population)		50	43	42	41	35
Crude death rate (per 1,000 population)		16	12	11	10	7
		About 1980		Most recent		
Contraceptive prevalence rate (%, 1979/1988)		14		43		
Population annual growth rate (%, 1965-1980/1980-1989)	Total	3.1		3.1		
	Urban	7.5		5.5		
ECONOMIC INDICATORS		About 1980		Most recent		
GNP per capita annual growth rate (%, 1965-1980/1980-1988)		1.7		-1.0		
Inflation rate (%, 1965-1980/1980-1988)		6		12		
Population in absolute poverty (%, 1977/1988)	Urban/rural	.. / ..		.. / ..		
Household income share (%, 1977/1988)	Top 20%/bottom 40%	.. / ..		.. / ..		
Government expenditure (% of total expenditure, 1980/1988)	Health/education	5/ 16		8/ 22		
	Defence	25		16		
Household expenditure (% of total income, 1980-1985)	Health/education			.. / 8		
Official development assistance: (1980/1988)	SUS millions	164		270		
Debt service (% of goods & services exports, 1980/1988)	As % of GNP	3		4		
		3		25		

a/ Aged 3-60 months.

b/ Aged 3-36 months.

c/ aged 24-60 months.

Definitions, sources and symbols are described in the section preceding these data sheets.

* UNICEF field office source.

** United Nations Population Division projections based on past and current trends.

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TABLE 2. EXPENDITURE UNDER PREVIOUS COOPERATION PERIOD, 1987-1990

(In thousands of United States dollars)

COUNTRY: ZIMBABWE

LATEST BOARD APPROVAL: 1987

GENERAL RESOURCES: \$6,150,000

	Supplies and equipment (incl. freight)		Training grants		Project staff		Other cash		Totals		
	GR	FSF	GR	FSF	GR	FSF	GR	FSF	GR	FSF	Total
Health	1716	1249	151	34	72	268	228	246	2167	1797	3964
Water supply and sanitation	300	369	27	1	281		89	448	697	818	1515
Nutrition	161		94				57		312		312
Education	377	260	84	35		36	141	283	602	614	1216
Community organization and development	282	1	12	20			68		362	21	383
Women-centred programme	146		13				10		169		169
Advocacy		43					2	25	2	68	70
Emergency	58	311	2	19				62	60	392	452
Planning and project support	127	39	9		558	34	209	165	903	238	1141
Freight	321								321		321
GRAND TOTAL	3488	2272	392	109	911	338	804	1229	5595	3948	9543

GR = General resources.

FSF = Funded supplementary funding.

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TABLE 3. PLANNED EXPENDITURE, 1992-1996

(In thousands of United States dollars)

Country: ZIMBABWE Period covered: 1992-1996	Funding status	1992	1993	1994	1995	1996	Total
Health	GR	200	200	200	200	200	1000
	NSF	240	240	240	240	240	1200
Water supply and sanitation	GR	200	200	200	200	200	1000
	NSF	300	300	300	300	300	1500
Nutrition	GR	50	50	50	50	50	250
	NSF	100	100	100	100	100	500
Education	GR	350	350	350	350	350	1750
	NSF	260	260	260	260	260	1300
Women-centred programme	GR	160	160	160	160	160	800
	NSF	150	150	150	150	150	750
Social mobilization and advocacy	GR	50	50	50	50	50	250
	NSF	50	50	50	50	50	250
Planning and social statistics	GR	50	50	50	50	50	250
Programme support	GR	140	140	140	140	140	700
Assistance to Mozambique refugees	NSF	200	200	200	200	200	1000
TOTAL	GR	1200	1200	1200	1200	1200	6000
	NSF	1300	1300	1300	1300	1300	6500
GRAND TOTAL		2500	2500	2500	2500	2500	12500

GR = General resources.

NSF = New supplementary funding.

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TABLE 4. STAFFING FROM BUDGET AND PROGRAMME FUNDS

COUNTRY: ZIMBABWE	Number of posts	Amount (thousands of United States dollars)

FINANCED FROM 1992-1993 PROPOSED BUDGET:		
International Professional established posts	3	634
Local national Professional and General Service established posts	10	432
Operating costs		680
Total	13	1746

FINANCED FROM PROGRAMME FUNDS: <u>a/</u>		
International Professional project posts		
General resources	3	655
Supplementary funds		
Local national Professional and General Service project posts		
General resources	15	540
Supplementary funds		
Total	18	1195

a/ For information source, see 1992 post authorization table, dated January 1991.
